Landscapes of Fertility in Rural South Africa: Intergenerational Understandings, Migration and HIV/AIDS

By

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A thesis submitted in partial fulfillment of the requirements for the degree of Doctor of Philosophy in Health and Social Sciences

University of Warwick, Medical School
September 2014

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Acknowledgements

Firstly, I would like to thank all the men and women who participated in this study. I wouldn't have been able to complete this piece of work without your help, particularly, the hours of your time you devoted to telling me the stories of your lives. Thank you, especially, to "Pumeleli", who has since passed away for her endless enthusiasm, explanation, clarification and help. You are greatly missed. "Elsie", the determination and passion you display, even in the face of your debilitating illness is an inspiration to all in your community, and to myself.

I was allocated a PhD scholarship by the University of Warwick, without which I wouldn't have been able to complete this work. For the first year, a generous benefactor pledged funding for my PhD, flights too and from South Africa, and payment for the implementation of a women's literacy programme in Mozambique. I would like to thank you for your generous contribution, both to my studies and to the programmes that are now sustainably implemented in Zavora, Mozambique by MozVolunteers, the social enterprise company of which I am a director. I would also like to thank Mary McGrath, Director of Major Gifts at the University of Warwick for awarding me this grant, and Professor Gillian Hundt for her support throughout the grant proposal process as well as her pivotal role in helping me secure this funding. The final years of my PhD were generously funded by the Graduate School at the University, who I would also like to thank for giving me this opportunity.

I have had the best PhD supervisors I could wish for – thank you to Professor Gillian Hundt and Dr. Maria Stuttaford for your tireless support, direction and all the comments on all the drafts that helped shape this thesis, and guide me to completion. Thank you for sharing your expertise and knowledge with me, and especially, for letting me complete my PhD from home in South Africa, whilst communicating via skype. I do, however, accept that this work is all my own responsibility, and any mistakes and errors are my own.

I also couldn't have conducted this research without the ethics permissions granted by UKZN. Thank you to all at the Africa Centre in Somkhele who facilitated this for me, and for accepting me as an affiliated PhD student. With special thanks to Professor Marie-Louise Newell and Dr Colin Newell as well as Suzette Grobler for all of your

administrative help, and being a friendly voice at the end of the telephone when I was struggling with the paperwork for ethics. Thank you to Thulio de Oliviera for your guidance with the analysis of SADHS incorporated into this thesis.

Thank you to all my friends who have supported me through the process – particularly Dr Julie Rasmussen and Hana Asfour, fellow PhD students, who I am looking forward to working with in the near future.

But above all, thank you to Dad, Mum and Scott. Thank you Dad for inspiring me to do this PhD, to Mum for your help and support, to both of you for your love and adaptation to my somewhat unconventional ways of doing things. To my partner, Scott for your tireless love, support, encouragement, the overtime that you have worked so I can complete this PhD and most of all your willing to negotiate my demands whilst building our house, which involved putting in the satellite for internet before the roof so I could complete my PhD.

Declaration

I, Alexandra Sunley Plowright, declare that this thesis is my own work and that it has not been submitted for any other degree at another university.

Date: 12.5.2015

Signed: 

Abstract

This thesis is based on a mixed methods study with a sequential exploratory design, and is about the fertility preferences of women living in rural South Africa. The quantitative secondary analysis utilises the South African Demographic and Health Surveys of 1998 and 2003, and the qualitative ethnographic fieldwork was carried out in a rural area of KwaZulu-Natal province, South Africa, in 2011 and 2012. The fieldwork included ethnographic field notes and maps generated through participatory mapping exercises, 63 semi-structured interviews with women of different generations and 6 key informant interviews.

The thesis examines women's landscapes of fertility and focuses on intergenerational understandings of fertility preferences, migration and the HIV/AIDS pandemic.

The thesis identified that women's landscapes of fertility are subject to change over time and differ between women of different generations. Older women's landscapes of fertility are influenced by understandings of the importance of continuity of family whilst those of younger women are synonymous with their experiences of increasing autonomy and agency, caused by escalating modernity.

For younger women, migration was a key issue within their landscapes of fertility and their migration later affected their mothers who became migratory followers of their daughters. This is a reversal of typical paradigms of migration, as it identifies that women from different generations can be migratory followers or leaders.

It was found that HIV influenced women's landscapes of fertility due in part to the South African, changing socio-political responses to the disease.

The thesis contributes to geographical and anthropological understandings about change in women's fertility preferences over time in the context of societal change. The thesis also identifies the value of ethnographically informed understandings of fertility preferences as a key indicator of demographic change and population shifts.

List of Abbreviations

AC	Amnesty Committee
AIDS	Acquired Immuno Deficiency Syndrome
ANC	African National Congress
ART	Anti-Retroviral Therapy
BEE	Black Economic Empowerment
COGTA	Cooperation of Governance and Traditional Affairs
COSATU	Congress of South African Trade Unions
CWP	Community Work Programme
GEAR	Growth Employment and Redistribution
GIS	Geographic Information Systems
HIV	Human Immuno deficiency Virus
HRV	Human Rights Violation Committee
HSSREC	Humanities and Social Sciences Research Ethics Committee
ID	Identification Book
IFP	Inkatha Freedom Party
IOM	Institute of Migration
KZN	KwaZulu-Natal
LO	Life Orientation
MCH	Mother and Child Health
NGO	Non-Governmental Organisation
NIDS	National Income Dynamics Study
OSS	Operation Sukuma Sakhe

OVCs	Orphans and Vulnerable Children
PMTCT	Post Mother to Child Transmission Therapy
PTSD	Post-traumatic Stress Disorder
RDP	Reconstruction and Development Programme
R&R	Repatriation and Rehabilitation Committee
SADHS	South African Demographic and Health Survey
SAMRC	South African Medical Research Council
SPSS	Statistical Package for the Social Sciences
STI	Sexually Transmitted Infection
TRC	Truth and Reconciliation Commission
UKZN	University of KwaZulu-Natal
USA	United States of America
VCT	Voluntary Counseling and Testing
WHO	World Health Organization
ZAR	South African Rand

Glossary

isiZulu	**English**
Bafihla	Hidden or invisible
Bheshu	Antelope skins worn by men at Zulu ceremonies
Capallana	Wax printed cloth sarongs worn by women
Dagga	Cannabis
izimpilo yamadomazane	Women's health
Khuluma	To talk
Kuwukudelela	Wild, rude, uncontrollable. Used to describe animals or children
Lobola	Bride price paid by the husband's family to that of his wife on marriage, similar to a dowry
Madala	Old man, also used by young people to mean patriarch in a derogatory sense
Mealie	Sweetcorn
Mhlungu	White person
Mphephu	Curry bush, used as a hallucinogen to facilitate conversations with ancestors
Njabulo	Happy
Nyangana	Mozambiquan food made from spinach of peanut leaves, crushed peanuts and

	coconut milk
Okhokho	Ancestors
Rondavel	Literally – round house, building for living in or communicating with ancestors
Sangoma	Traditional healer
Shebeen	Illegal bar
Thansi	Sleeping mat made from reeds, woven together
Tsotsi	Criminal
Umntwana wami	My baby
Ukunakekela	Caring for another person
uMuhla	Modern
uMuthi	Traditional medicines
uWashe	Slang word for popular area to wash clothes

Introduction

This thesis is a study of women's landscapes of fertility. This topic is explored within the changing socio-economic context of South Africa, as well as its intersection with migration and the South African HIV pandemic. Fertility is a biological condition and a social construct and is an important topic relevant to the disciplines of geography and anthropology. Extending understandings of fertility can help to forecast potential change, on both global and local scales, to population levels (Gerrits 1997). This forecast is necessary in order to ensure that the correct services and facilities are available for the population of different countries and regions within countries (ibid). Fertility levels can be influenced, amongst other factors, by the fertility preferences of men and women (Moultrie et al 2008). This thesis, therefore, concentrates on extending understandings of women's fertility preferences as one component of their landscapes of fertility.

Fieldwork for this PhD research was undertaken in South Africa. South Africa is a country typical of many in sub-Saharan Africa and is currently experiencing a fertility decline (Moultrie et al 2008). This means that birth rates are reducing. As a consequence it is important to extend knowledge about the potential reasons for this subsequent reduction in population levels. This thesis, therefore, explores women's perspectives on their fertility preferences and choices, and the intersection of these with migration and HIV, both of which are processes that have had an influence on rural communities in South Africa.

Migration is the movement of people from one place to another. It can be forced or voluntary, and is usually stimulated by push and pull factors that provide the motivation for the movement. On a global scale, migration has occurred for centuries, but has

become a formalised, documented (or un-documented) process since the establishment of national state jurisdiction (Haour-Knipe 2009).

In the context of South Africa, voluntary migration to the country is usually labour-motivated. Large numbers of migrants travel from less-affluent, home countries in sub-Saharan Africa to South Africa every year. Some are documented, but most are undocumented (IOM 2010). Thus it can be suggested that migrants move from situations of structural violence created by poverty in their home communities. However, these migrants then become exposed to further structural violence caused by the process of migration, the political economy of the migrant labour, their often undocumented status and the repercussions they suffer in terms of the healthcare and welfare structures in South Africa. This thesis, therefore, explores migration as a component of landscapes of fertility.

HIV is explored in this thesis as a further component of women's landscapes of fertility. HIV was initially understood to be an infectious disease argued to only affect gay men. However, later study of biomedical evidence identified that HIV actually had a greater impact on heterosexual men and women, which was particularly evident in sub-Saharan Africa.

South Africa has been acutely affected by the HIV pandemic, and infection levels are some of the highest in the world, with the black African population of the country being the worst affected. Initially, the political response to the disease was "disastrous" (Lengwe Kunda and Tomaselli 2012:71) as then president Thabo Mbeki and minister for health Dr Tshabalala MSimang failed to co-ordinate an effective and biomedically sound public health response to the threat posed by the disease (May 2000). Later, under the presidency of Jacob Zuma and Minister for Health Dr Aaron Motsoaledi, antiretroviral therapy (ART) rollout was well coordinated, and associated government

health services improved. As a result, infection levels, and mother to child transmission levels of the disease improved. As a consequence of these two varied political responses to the disease, women from different generations have had a different experience of the HIV pandemic in South Africa. This thesis explores the intersection of these intergenerational differences in experience and attitude towards HIV with landscapes of fertility through study of agency and resilience as an expression of agency demonstrated by women and households.

The intersection of fertility, migration and HIV are explored in the thesis using a framework developed from landscapes, structural violence, agency and resilience. Through adoption of this framework, the structuralist and humanistic influences on landscapes of fertility are identified.

This research was completed using multiple methods within a sequential exploratory research design. The thesis aims to extend understandings of women's landscapes of fertility by answering the following three research questions:

1. What are women's intergenerational understandings of landscapes of fertility within the context of the changing socio-economic context of rural South Africa?
2. How do patterns of migration intersect with women's landscapes of fertility?
3. To what extent does the HIV/AIDS pandemic in South Africa contribute to women's landscapes of fertility?

Chapter One locates the thesis within existing literature about fertility, landscapes, structural violence, agency and resilience and migration. The chapter identifies the conceptual framework adopted in the thesis, which is devised from the landscapes framework as prescribed by the New School of Cultural Geographers, and serves to

identify structuralist and humanistic contributions to women's landscapes of fertility. The chapter concludes by identifying the three research questions that are addressed in the thesis.

Chapter Two sets out the socio-political context of the thesis. It describes the history of South Africa as a background to this study, as well as a contextualization of the geographic and socio-economic details of Khaya'manzi[1], which is the study site for this PhD research.

Chapter Three is a discussion of the methods employed in this thesis, ethical concerns and the positionality of myself as the researcher. The chapter presents the research design and methods used as well as the rationale for this study, ethics and a discussion about negotiating access to study participants.

Chapters Four to Six are where the findings of this research are presented. Each of these chapters answers one of the three research questions: Chapter Four is an exploration of the local understandings and experiences of study participants of their fertility choices, preferences, consequences and related concepts. Part A presents quantitative findings pertaining to change in ideal number of children of women between 1998 and 2003, and the factors that may be associated with this change. Part B extends the findings presented in Part A through exploration of women's intergenerational understandings of their landscapes of fertility. These understandings are then discussed in relation to migration and HIV in Chapters Five and Six.

The final Chapter Seven of the thesis presents the conclusions. Here, I summarise the key conceptual findings as well as the empirical contribution this thesis makes to

[1] Khaya'manzi is a fictitious name for the fieldwork site. I have concealed the true identity of the fieldwork location, and places located within it, in order to protect the anonymity and confidentiality of participants.

knowledge. The chapter identifies the limitations and strengths of this research, as well as the ethical concerns. The chapter also presents recommendations in relation to policy and practice and suggests opportunities for further research.

Chapter 1: Literature Review and Conceptual Framework

This chapter locates the thesis within current academic scholarship about fertility, which includes women's fertility and fertility preferences; the morphology of the landscapes framework; structure and agency; structural violence and resilience and finally, migration. The chapter provides a critical, background review of relevant literature, establishes a conceptual framework of landscapes of fertility for the research and sets out the research questions to be answered.

1.1 Fertility

Fertility is a biological condition, yet also a social construct. Understandings and meanings of fertility vary between different societies, contexts and throughout the life cycle of girls and women. Fertility levels refer to the number of living children a woman has within her lifetime and can be influenced by a woman's fertility preferences. Fertility preferences, however, involve complex decisions, change over time and are influenced by external factors. One of the reasons it is important to understand fertility preferences is because they may be indicative of future change in the demography of regions (Gerrits 1997). However, fertility is usually studied from a biomedical perspective and usually using quantitative methods. Consequently, research about fertility is usually situated within the topic of biomedical, sexual and reproductive health of men and women. First, literature concerning fertility is reviewed followed by literature relating to women's fertility preferences.

Fertility and Sexual and Reproductive Health

Fertility is located within a wider area of study concerned with sexual and reproductive health. In the past, research into sexual and reproductive health predominantly focused

on women and concentrated on extending knowledge about childbearing and related concepts (Stacey 1988). As a consequence there were many studies that explored mother and child health (MCH). Studies of this kind were predominantly conducted from a biomedical perspective, and initially concentrated on obstetrics (for example Boddy 1998; Chapman 2003) pregnancy (for example Gruenbaum 1998) infant mortality and child health (Brockerhoff and Hewett 2000). This approach to studying sexual and reproductive health has been criticised for its concentration on child health, and its exclusion of women's experiences of childbearing, childbirth and other aspects of women's sexual health (Rosenfield and Maine 1985). Culley and colleagues further argue that men have systematically been excluded particularly from research of this kind about fertility that is located within the field of reproductive health (Culley et al 2013).

As a consequence of this critique, the focus of scholarship about sexual and reproductive health shifted to include these wider issues associated with women and men's health. Thus, more recent studies concerning sexual and reproductive health include medical conditions and experiences associated with the reproductive health of women of all ages (Brunson 2010; Hough 2010; Jeffrey and Jeffrey 2010; Van der Sijpt 2010; Paul et al 2011; Conry 2013). For example: pregnancy, family planning, female genital mutilation, maternal and peri-natal health, reproductive tract infections, STI's (including HIV/AIDS) unsafe abortion, violence against women and fertility or infertility (Sadana 2002). There has also been the development of a body of literature that focuses on men's experiences of fertility, infertility and fatherhood (for example: Brandth and Kvande 1998; Williams 2009; Culley et al 2013; Dolan 2013). This literature is not included in this review, owing to the focus of this thesis being women's experiences of fertility preferences but is acknowledged to be an important and significant development.

The study of fertility is therefore often still predominantly located in the wider field of women's sexual and reproductive health but multidisciplinary approaches are broadening and deepening understandings of fertility from different perspectives (Boyle 2013).

Women's Fertility

In different contexts, fertility is assigned different meanings and levels of importance. However, the dominant understanding is that fertility and having children is usually the woman's responsibility and is often associated with gender roles within different socio-cultural contexts (Gerrits 1997; Ardabily 2011). Consequently, *in*fertility has often been perceived to be the fault of the woman (Ardabily 2011). Research into the topic has mostly concentrated on women's fertility and the intersection of fertility with sexuality and gender roles.

Much research on women's fertility has been undertaken using quantitative methods and has extended knowledge about fertility levels in both the majority world and economically affluent countries (Reissman 2000; van Balen and Gerrits 2001; Leonard 2002; Bos et al 2005; Nahar 2007). Research about fertility has typically incorporated quantitative analysis of survey data and has presented an important insight into regional, biomedical perspectives on women's fertility levels. However, Gerrits argues that there is an absence of knowledge about women's lay understandings and women's experiences of their fertility (Gerrits 1997). Later literature about fertility consequently addressed this gap, through research in the fields of anthropological demography and gender studies.

Anthropological demographers use anthropological methods in order to extend understandings of population processes, of which fertility is a prominent example

(Bernardi 2007; Bachrach 2014). Scholars from this discipline have extended knowledge about fertility through research into fertility declines and fertility transitions (McDonald 2000; Townsend 2000) as well as fertility within specific population groups (Mussino and Raalte 2008). Whilst Anthropological demography has contributed to literature about fertility, its methodology could be adopted in the study of fertility preferences, and to extend understandings of women's experiences of their fertility.

In order to address concerns raised about the absence of knowledge about women's experiences of their fertility, research has been undertaken that investigates women's experiences of fertility and infertility in conjunction with theories of gender (Inhorn 2003).

Gender studies first became popular as a discipline, when a distinction between gender and sexuality was made in Western academic scholarship in the 1960's (Tamale 2008). Whilst sex was determined to be the biological attribute that makes an individual female or male, gender was understood to be the "socially constructed and culturally variable roles that women [and men] play in their daily lives" (Meena 1992:24). Research about women's experiences of fertility has addressed the intersection of fertility or infertility and gender across different regions (Inhorn 2003; Feldman Savelsberg 1994; Gerrits 1997; Ardabily 2011; Dimka and Dein 2013). However, Inhorn argues that research that addresses fertility through a gender lens is usually conducted from a Western feminist standpoint (Inhorn 1994). Consequently, it can be suggested that these studies may have inadvertently disempowered women from the majority world, and may be exclusionary in nature (Inhorn 2003).

Gender scholars from all backgrounds and regions concur that gender roles are founded in inequalities, and hegemonic masculinity is constructed to maintain patriarchal dominance of femininity (Meena 1992; Okonto 2007; Tamale 2008). It can also be

suggested that women from societies the world over are often marginalized and disempowered, which may be due to their societally prescribed gender roles (Petchesky 2000).

However, regional gender scholars, particularly those from the African School of Femininity are sometimes critical of the Western feminist standpoint as it can be understood to disempower women due to its reliance on theoretical dichotomies. Scholars from perspectives like the African School of Femininity have adopted post-modernist principles in order to move beyond the modernist liberal and radical feminism, under which Western feminism can be bracketed. Thus conventional theoretical dichotomies can be rejected, and instead scholarship can concentrate on the more complex intersection of topics, context and concepts. This correlates with the principles of the landscapes framework adopted in this thesis, which is discussed in detail in section 1.2.

Meena, a scholar of the African Femininity Perspective, argues that Western, modernist feminism systematically discriminates against men, male perspectives and ignores the influence of men in women's lives (Meena 1992; Claeys 2007). Other, non-Western scholars have applied this same perspective to gender and fertility and argue that research about fertility has excluded men and masculinities, and does not take into account men's perspectives nor their role in fertility (Inhorn 1994). As a response to criticism of this kind, research was conducted, during the early and mid 2000's, that aimed to extend knowledge about men's perspectives on and feelings about infertility (for example Papreen et al 2000; Inhorn 2003; Dyer et al 2004; Wentzell and Inhorn 2014).

Despite these more recent studies concerned with masculinities and male perspectives on fertility, it is argued that, particularly intergenerational understandings of fertility

could be further extended through study of the topic within the household (van Balen and Gerrits 2001). Consequently an appreciation of the perspectives of both men and women, from different generations, on fertility could be developed within one study, rather than as previously in separate, gendered studies (van Balen and Gerrits 2001; Dyer et al 2004).

This thesis, therefore, takes into account fertility within the context of the household by exploring intergenerational understandings of women on the topic. This is achieved by using interviews with women of all ages. The perspectives of men on the topic are included through the accounts of women, or as participants in group interviews but not as individual interviewees owing to the constraints of the local socio-cultural context and the decision to focus on women's experiences and understandings. This study adopts a regional gender lens, that of the African Femininity Perspective, to facilitate interpretation of the fertility choices of women in the context of migration and the HIV pandemic in South Africa.

Fertility Preferences of Women

Women's fertility preferences are a component of the wider topic of fertility. Fertility preferences refer to the choices that women make to have children, and why they wish to have a certain number of children. Fertility preferences are understood to indicate fertility outcomes and are used to inform policy and planning for future, regional populations (Bongaarts 1982). Fertility preferences are generally the subject of quantitative studies and are often used to inform knowledge about projected, average family size (ibid.). Fertility preferences are usually identified in surveys as a female participants' "ideal number of children", and responses consist of numerical values. Studies about fertility preferences have typically been conducted by demographers, and usually incorporate primary or secondary, quantitative analysis of survey data. Studies

concerning fertility preferences have addressed women's ideal number of children within designated geographical areas and factors that are associated with change in the ideal number of children of participants (for example see Kodzi et al 2010a; Kodzi et al 2010b; Sennot and Yeatman 2012; Yeatman et al 2014).

Studies have identified the fertility preferences of women for use as a short-term demographic predictor of local fertility levels (Bongaarts and Feeney 2003; Westoff and Cross 2006; Kodzi et al 2010a). However, Kodzi and others argue that women's fertility preferences are subject to change over time in accordance with changes in participants' circumstances (Kodzi et al 2010b; Bankole and Wesstoff 1998; Debpuur and Bawah 2000; Sennot and Yeatman 2012). Longitudinal studies have demonstrated how women's fertility preferences change over time, and illustrate the consequent unreliability of fertility preferences as a demographic indicator (Kodzi et al 2010a). Kodzi and colleagues further argue that in order to add value to the study of fertility preferences, it is necessary to extend understandings of the factors associated with this transient nature of women's fertility preferences in relation to time (Kodzi et al 2010). Understandings of these factors are important, as they can provide explanations for these identified changes in women's fertility preferences. These explanations can then be used to inform and better understand future demographic trends (Kodzi et al 2010a). This topic may be further extended through the construction of intergenerational studies to better understand factors that influence change in the fertility preferences of women through different generations.

This thesis, therefore, explores intergenerational perspectives on women's fertility preferences in order to extend knowledge about how factors influencing fertility preferences may change between generations. Thus, the thesis will explore how fertility preferences may be different for women from different generations.

To date, research has explored the influence of modernity, HIV and migration on changes in women's fertility preferences. This has been achieved mostly using quantitative methods within the discipline of demography.

Modernity is a concept that can be associated with a reduction in women's ideal number of children (Colleran et al 2014). The various factors and circumstances that are associated with modernity can influence women's ideal number of children (Colleran et al 2014). For example, the increased access to hormone-based contraception that is associated with the modernisation of healthcare services can reduce women's ideal number of children (Baschieri et al 2013; Do and Kurimoto 2012; Withers et al 2010). In addition the influence of improved education of women can be associated with a reduced ideal number of children (Colleran et al 2014).

It has also been suggested that experience of the HIV pandemic has changed women's fertility preferences (Heys et al 2009; Cliffe et al 2011; Hayford et al 2011). Research has extended knowledge of the association between HIV and fertility preferences in order to advise on family planning availability to HIV positive couples in majority world countries. It has been found that knowledge of HIV status reduces women's fertility preferences because of vulnerability and risk associated with inter-utero, mother to child HIV infection (Yeatman 2009). However, this perspective fails to take into account improvements in access to anti-retroviral therapy (ART) and post mother to child transmission therapy (PMTCT) that can reduce risk of infection. Nor has existing research acknowledged contextual influences, such as economic migration. Migration and mobility has been found to have a statistically significant influence on change in women's fertility preferences and child-bearing patterns, regardless of HIV status (Kulu 2005). However, the complexities of these intersecting topics pertaining to fertility, HIV, migration and fertility preferences have not been addressed. This thesis, therefore, explores the intersection of HIV, migration and associated issues within the wider topic

of women's fertility across generations. Thus, the complexities of the interaction of these topics and their influence on women's fertility preferences within their landscapes of fertility may be better understood.

Fertility and Fertility Preferences in the South African Context

Fertility levels in South Africa are in decline. Average births per women have reduced from 2.86 in 1998, to 2.48 in 2010 (Moultrie et al 2008; Statistics South Africa 2010). Numerous explanations for this fertility decline have been proposed, such as, changing fertility choices influenced by HIV/AIDS (Cooper et al 2007; Dyer 2007), education and modernity (Caldwell 1980; Schwartz 2009) and increasing biomedical infertility levels that are attributed to sexually transmitted infection (Cooper et al 2007). Schwartz argues that this decline is rapidly becoming a major public health issue and has the ability to impact on South African society in terms of policy and service provision (Schwartz 2009). However, it is clear that there is a notable absence of literature that addresses women's personal choices and perspectives on fertility and fertility preferences specifically within the South African context (Schwartz 2009 Caldwell 1980; Cooper et al 2007 and Dyer 2007; Schwartz 2009). Consequently, it can be argued that further study of women's fertility and associated issues within the South African context is needed, in order to extend understandings about the complex reasons for this national fertility decline.

Section Conclusion

It has been demonstrated that fertility levels are indicative of future demographic trends within regions. Fertility is usually studied as an element of biomedical, sexual and reproductive health. Existing research has addressed fertility, predominantly using quantitative methods, using a Western gender lens. Initial research on fertility tended to

focus on women, and it has been argued that men's experiences of their fertility were not taken into account until more recently. In addition, gender sensitive analyses of household perspectives have not been explored. Women's fertility preferences are understood to be transient and subject to change over time, perhaps due to changes in external influencing factors, such as HIV and migration. Consequently, it can be argued that fertility preferences are unreliable as an indicator of fertility, unless explored in relation to these external influencing factors. The study of women's intergenerational views on fertility and fertility preferences could extend knowledge about changing perspectives, particularly between different generations. Study of the complex intersection of these external factors such as migration and HIV that may influence women's fertility preferences could extend knowledge about the topic. As a result, changes in fertility levels in different countries, such as South African general fertility decline, could be better understood.

This chapter section has consequently positioned the thesis topic within literature about women's fertility and fertility preferences. However, this research concentrates primarily on extending understandings of fertility preferences, as one aspect within the wider topic of landscapes of fertility. There are other aspects that are relevant to the topic. The next section of this chapter will explore in detail the concept of landscapes that is adopted in this thesis. This concept is used as a means of framing the exploration of the intersection of fertility preferences with household level intergenerational understandings, migration, modernity and HIV.

1.2 Landscapes

The conceptual framework adopted in this thesis is based on the landscapes framework that stems from scholarship from the New School of Cultural Geography. This concept is explored to reveal the landscapes of fertility of women that incorporate the additional

ideas of structural violence, agency, resilience and migration in order to better understand fertility in rural South Africa. By incorporating these concepts into the framework a contribution is made to New Cultural Geography and theories of landscapes. Whilst landscapes of fertility can be argued to include with equal importance: fertility, infertility, men's fertility, fertility preferences and others, this thesis will concentrate on extending understandings of women's fertility preferences as one component of their landscapes of fertility.

Landscapes is a concept widely used in academic literature in geography and other social sciences. Despite having a clearly prescribed meaning and framework, it has been argued that the concept of 'landscapes' has been exploited through overuse and the underlying meaning and history of the term and what it represents is sometimes overlooked (Milligan and Willes 2010). It particularly refers to the complex relationships that people have with space. Of particular relevance to this thesis, the landscapes framework has been used in health research to extend understandings of care and power.

The morphology of landscapes

The study of landscape originated from the European school of Landschaftography, which can be traced back to the late nineteenth century (Johnston et al 2010). Initial study located particular physical landscapes within greater regional contexts (for example, Grigg 1965; Haggett 1965). Gradually the study of landscapes evolved and natural landscapes were distinguished from cultural landscapes (Mitchell 2000). Scholars from the School of Cultural Geography (also known as the Berkeley School) further extended this topic to facilitate investigation of the development or 'morphology' of cultural and natural landscapes over time (Sauer 1925:43). During this period, it can be argued that the discipline divided into two areas of study. Firstly,

physical geography, as the study of natural landscapes and secondly, human geography, which was the study of cultural landscapes (Mitchell 2000).

Carl Sauer was a prominent scholar of cultural landscapes. His initial work was concerned with the structuralist influences on landscape creation, and later he studied humanistic aspects of landscapes (Sauer 1925). These two perspectives on landscape scholarship led to the formation of the structuralist and humanistic schools of thought that developed over the following century. However, humanistic and structuralist scholars had conflicting opinions, and regularly engaged in ideological disputes about the value of the other's discipline and perspectives on interpretation of issues present within landscapes (Mitchell 2000). The conflict between the two schools of thought is understood to have hindered the production of knowledge about landscapes during the twentieth century (Gesler 1992). As a response to this critique and gap in knowledge production, the New School of Cultural Geography was formed in the 1990's. Scholars such as Cosgrove (1987; 1998) Massey (1991) and Gesler (1991; 1992; 1998) developed a new way of using landscapes as a framework to extend understanding of different topics. This involved the application of social and cultural theory to form a landscapes framework for understanding, whilst still retaining some links to the origin of the concept devised by the original School of Cultural Geography (Mitchell 2000).

Cosgrove was a prominent scholar from the New School of Cultural Geography. During this period, he redefined landscapes as "a way of seeing and understanding" (Cosgrove 1998: 5). This meant that landscapes could be used as a framework to extend knowledge about the complexities and intricacies of a topic, rather than as a simple description or basic interpretation of a concept (Gesler 1992). Cosgrove and others from the New School of Cultural Geography devised a landscapes framework that used a combination of humanistic and structuralist perspectives to extend

understandings of complex issues in the creation of fully inclusive, comprehensive landscapes framework (Gesler 1992).

The new landscapes framework aimed to blend the two schools of thought in an attempt to resolve conflict between scholars. This resolution of conflict would be achieved through the incorporation of the principles of Heidegger's (1962) concept of Dasein into the philosophy that underpinned the framework. Dasein is a concept that emphasises the necessity of being present in the studied world, and the subsequent importance placed on the study of embodied practices and processes, rather than surveillance of the studied phenomena from a distance. This is in direct contrast to the principles of the previous, School of Cultural Geography, who concentrated on developing a direct theoretical representation of the world, which often promoted conflict between scholars of different affiliations. Geographers from the New School of Cultural Geography, however, focused rather on intersections between different, often dichotomous, concepts, and the lived experience of a certain context. Consequently, this made room in the discipline for study of humanistic and structuralist elements of a landscape and their interaction through the incorporation of interrelated dichotomies to extend understandings of the complexities of any phenomenon (Cosgrove 1998). For example, previously, scholarship from the School of Cultural Geography may have addressed *either* the structures *or* the examples of agency present in a landscape. However, scholars from the New School of Cultural Geography, argued that the landscapes framework could only be used to understand structure as long as agency was studied with equal weight. A landscapes framework could also be used to extend knowledge about society, as long as the perspectives of individuals were studied too (Gesler 1992).

Cosgrove anticipated that this new landscapes framework would result in "fruitful cooperation between humanist cultural geography and structural geographers" and would produce a new way of thinking, and valuable knowledge creation (Cosgrove

1987:95). However, in reality, it proved difficult to inspire this "fruitful co-operation" (ibid.), and academic conflict between humanistic scholars and structuralists continued. Humanistic scholars concentrated on developing understandings of landscapes through their underlying discourse whereas structuralists explained landscapes using the processes and flows enacted in certain spaces. Structuralist scholars further critiqued humanistic scholars for being one-dimensional. Simultaneously, it was claimed that the humanistic perspective refused to acknowledge the impact of external structure on landscapes. However, structuralists were criticised for focusing too heavily on structures within a landscape, and ignoring the impact of human agency (Cosgrove 1987). This continued conflict between the two schools has resulted in the generation of a polarised body of literature. Consequently, it has been suggested that the New School of Cultural Geography's landscapes framework has been used inappropriately and generally a piece of research incorporates just one perspective from a conceptual dichotomy (Milligan and Willes 2010).

This thesis, therefore, adopts the landscapes framework as proposed by Cosgrove and others from the New School of Cultural Geography, as the overarching conceptual framework and has applied it to fertility. The additional adoption of a regional gender lens, that of the African Femininity Perspective, which is a post-modern school of thought, as a lens through which this landscape is explored, can facilitate gender and regionally sensitive knowledge about the complex intersection of concepts, context and topics concerned with landscapes of fertility, that is not exclusionary (this is discussed in more detail in section 3.2).

In response to critiques of previous research, the landscapes framework used in this thesis will incorporate the concept of structural violence in order to explore the structuralist elements of landscapes of fertility, whilst agency and resilience will be explored as an expression of individual or household level agency to extend

understandings of the humanistic aspects of landscapes of fertility. The intersection of fertility preferences with household level intergenerational understandings, modernity, HIV and migration will be explored.

A further concept, migration, will also be incorporated within the landscapes as a contextual factor that has been demonstrated to influence fertility preferences (Haour-Knipe and Rector 1996). Each of these additional concepts is a dimension of landscapes of fertility and incorporated into the thesis to explore the structuralist and humanistic elements of the landscapes. Thus, a balanced understanding of both the structuralist and humanistic elements of the landscapes will be presented in this thesis, as will the intersection of these complex processes and topics within landscapes of fertility.

While the limitations of existing studies conducted using landscape theory is acknowledged the concept and approach have been effectively applied to different contexts of relevance to this thesis surrounding landscapes of care and landscapes of power, which can include consideration of structure and agency and critical realism.

Landscapes of care

Scholarship about landscapes of care is relevant to this thesis. The study of landscapes of care originates from academic scholarship on therapeutic landscapes and landscapes of despair (Gesler 1982). Landscapes of care are used to explain personal experiences of the complexities of care surrounding a particular medical condition in relation to space. Milligan and Willes suggest that "care and care relationships are located in, shaped by and shape particular spaces and places " (Milligan and Willes 2010: 736). Hence, landscapes of care can be the articulation of care through "the differing…social spaces that enable caring interactions" (Milligan and Willes 2010: 737). Research that

has developed an understanding of landscapes of care has included: care-giving (Joseph and Hallman 1998; Smith 1998); care-receiving (Willes 2003); employment (Rose 1993; Dunkley 2009); gender and care expectations (Gilligan 1992); exclusion and inclusion (Power 2009).

Existing research has been critiqued for being Western-centric, and ignoring care and conditions specific to majority world countries (Milligan and Willes 2010). Research that has addressed landscapes of care has focused predominantly on chronic disease, rather than infectious disease and so has excluded majority world countries that have a different health profile, like South Africa, from its reach. Landscapes of care rarely include, simultaneously, the experiences and perspectives of the carer and the cared for and so are unable to fully explain the intricacies of care. Landscapes of care have not addressed structural difficulties, and have, instead concentrated on the humanistic interpretation of personal experience of care, or caring in the context of a specific disease. Understandings of landscapes of care could also be extended by addressing the gendered aspects of care, as there is currently a notable absence of research about this topic (Milligan and Willes 2010).

This research, therefore, explores the experiences of the cared for and the carer within the landscapes of fertility. This is achieved through exploration of the HIV pandemic in South Africa and changing patterns of care within the household and its relevance to fertility. Consequently, understandings of the association between caring or being cared for and fertility can be better understood.

Landscapes of power: Structure and Agency, Critical realism

A final use of the landscapes framework that is relevant to this research is that of landscapes of power. Landscapes of power facilitate the understanding of the

interaction of structure and agency, and how this can impact upon the health of individuals and groups (Curtis 2004). Certain societal structures are seen to impede the agency or choice of some individuals, resulting in inequalities between groups of people (Giddens 1984; Curtis 2004). The work of key theorists such as Bourdieu, Giddens and Archer has been incorporated into the landscapes framework to further understand power relations within society (Curtis 2004). The perspectives of these theorists are then extended further in this thesis through discussion of structural violence and resilience.

Structure and agency

Structure refers to the institutional or societal, historical or socio-cultural regulations, norms or arrangements that can influence or constrain human behaviour. Structures are often associated with agency, which is the capacity that individuals, households or groups of people have to act independently, and make their own choices (Giddens 1984). In the study of landscapes from the School of Cultural Geography, either structure or agency would be studied in a landscape. The two concepts were only reconciled and appreciated as an interrelated, interdependent dichotomy in the landscapes framework prescribed by the New School of Cultural Geographers at a later date. Key theorists, such as Bourdieu, Giddens and Archer addressed the concepts of structure and agency, either as interrelated, or independent ideas to explain social and societal organisation.

Bourdieu argues that structure and agency are interrelated. The scholar reconciled the concepts of structure and agency into one theory called 'practice' in order to explain social relations (Bourdieu 1977). He argues that there are social 'fields' in which social actors are socialized and negotiate power relations and various 'capitals' (for example, social capital) within these fields as they live. 'Fields' and what they consist of are

Bourdieu's term for the traditional concept of 'structure'. Over time, the individual accumulates social experiences, emotions and understandings, which form the individual's 'habitus' or agency. Bourdieu argues that habitus and fields are created in, by and through social practice. Consequently, neither habitus (agency) nor field (structure) could exist in the absence of social practice. Furthermore, social practice consists of fields and habitus that are continually evolving and re-evolving. Social actors develop habitus in order to overcome and negotiate various fields (Bourdieu 1977, 1993).

However, not all scholars concur that social actors develop levels of habitus (agency) in order to overcome and negotiate fields (structures). For example, Giddens, in his (1984) structuration theory, argues that structural features of society can be constraining or enabling, and therefore shape the agency of individuals (Giddens 1984). Giddens also presents the concept of time-space distanciation. This is the concept that allocative (for example technology) and authoritative resources (for example life chances or opportunities) constrain the life paths of some individuals. Consequently, this facilitates the maintenance of power disparities and inequalities in society (Giddens 1984).

A further contrasting perspective on the interaction of structure and agency is that adopted by critical realists. In particular, the work of Margaret Archer, who introduced the concept 'morphogenesis' (1982; 1995; 2007). Archer identified the problems associated with theorisation of structure and agency as an explanation for inequality and, whilst in agreement with Giddens on the conceptualisation of structure and agency in one single theory she offers morphogenesis as a critique of Giddens' work. Archer argues that at any given moment there are antecedentally existing structures that constrain and enable agents, who in turn act to negotiate these structures. However, instead of accepting the impeding nature of structure, Archer suggests that structures

can be changed by the actions of agents, as well as reproduced and adapted to facilitate further negotiation (Archer 1995). Subsequently, Archer's understanding and conceptualisation of structure and agency differs from that of other scholars as she argues that it is not just the agent that changes and adapts (as in Bourdieu's theory of habitus) but the structure does too.

In Archer's theory of morphogenetic sequence, she argues that structural or cultural factors that impact on the situation in consideration can be isolated to better investigate the action or agency of actors and better understand how these actions then reshape and change the initial context or structures (Archer 1995).

These theories and concepts can be incorporated into the landscapes literature to explain structure, agency and power disparities within different socio-cultural contexts (Curtis 2004). It is subsequently argued in this thesis, that individuals and households express agency within their landscapes of fertility.

Agency is expressed in order to negotiate constraining structures present within landscapes of fertility, which may impact on the independent thought and actions of households and individuals. These structures may be institutional, socio-cultural, societal or could be in existence because of current governance or, in the South African context of historical legislation.

Agency may be seen as having a polar dichotomous relationship with structure in which there is a dualism, with structure impeding most if not all, personal agency (Giddens 1984). However, this may be a simplistic perspective on the intersection of structure and agency. Consequently, it is argued that within situations of disadvantage, whilst impossible to exert "real control" (Seymour 2012:375), people are, however, able to exercise agency and choose between "sub-optimal alternatives" (Seymour 2012; 376;

Hart 2008). Boyden and others argue that individuals express different levels of agency in accordance with the different life experiences they have had. In order to better explain these different levels of expressed agency, Boyden defines agency as "[a person's] constructive engagement with adverse societal conditions" (Boyden 2010: xi). Scheper-Hughes further argues that even in the most unimaginably extreme situations of disadvantage, "people express a historically situated, and culturally elaborated capacity for resilience" (Scheper-Hughes 2008:52). Consequently, it can be suggested that different individuals or households exercise different levels of agency within the constraints of the structures that are present in their personal situations (Bourdieu 1993; 1977).

Therefore, within landscapes of fertility, it is proposed that as well as accepting the impact of impeding structures on their lives, individuals and households may also express agency in terms of methods of coping through use of livelihood strategies and demonstrate that they are capable of decision-making and choices within the constraints of their situations (Seymour 2012). As a consequence, it can be suggested that individuals negotiate structures in order to achieve basic daily needs (Scheper-Hughes 2008; Quesada et al 2011).

This thesis argues, therefore that within landscapes of fertility, individuals and households exercise agency, when confronted with situations of structural disadvantage. However, the kind of structural disadvantage most relevant to landscapes of fertility is that of structural violence, as proposed by Paul Farmer and explored in section 1.3.

Section Conclusion

The use of landscapes has evolved to a loose spatial metaphor from its previous use as a comprehensive inclusive framework for understanding. As such, its value as a tool for

extending knowledge has been reduced or lost (Milligan and Willes 2010). Therefore, research concerning landscapes and health could benefit from being reconceptualised to better incorporate the true origins of the term. In doing so, this could result in the creation of comprehensive research that is able to develop a deep understanding of the highly complex relationships between people, places and care. This thesis uses the landscapes framework as prescribed by Cosgrove and incorporates both structuralist and humanistic understandings within the study of fertility. The thesis will include theories of structural violence, as a structuralist contribution to the landscape, alongside agency and resilience, as an expression of this agency, in order to better understand the humanistic elements of landscapes of fertility. This incorporation of both structuralist and humanistic perspectives within the study will facilitate the development of inclusive, comprehensive understandings of the complexities of women's experiences and understandings of their fertility preferences, choices and consequences. The next section of this chapter explores the concepts, structural violence and resilience as an expression of agency and locates them within the landscapes framework that is used to explore fertility.

1.3 Structural Violence and Resilience

Structural violence can be understood as the social, cultural or institutional structures that prevent individuals or households from reaching their full potential (Galtung 1969). Structural violence is a process that is, arguably, mostly present in majority world countries, of which South Africa, because of its turbulent socio-political history and institutionalised discrimination of the Apartheid era, is a prominent example. However, within the constraints of circumstances of structural violence, it can be argued that individuals and households negotiate impeding structures, and demonstrate agency (Bourgois and Scheper-Hughes 2004). Agency can be extended to incorporate

resilience at an individual and household level to explain behaviour of individuals and households when confronted with situations of structural violence.

Structural Violence

Structural violence as elaborated by Farmer (1999), is then a relevant concept adopted in this thesis to describe the structural constraints present in landscapes of fertility. Farmer explains how in some locations, institutionalized systems and structures prevent an individual from exercising agency and consequently, can hinder their ability to make choices, particularly regarding their health. The author argues in his study of the impact of TB and HIV in Haiti and South America that structural violence commonly affects the poorest in society. Individuals are unable to break free of the constraints of structure, constraining their agency in seeking health care and adhering to treatment (Farmer 1999; 2005; 2006; Fassin 2007).

Farmer's structural violence is elaborated from the concept first introduced by Johan Galtung. Galtung first introduced the term 'structural violence' in an article entitled "Violence, Peace and Peace Research" (Galtung 1969). Galtung's structural violence pertains to the social, cultural or institutional structures that prevent individuals from achieving their basic needs (Galtung 1969). These structures create violence in the lives of individuals from the most disadvantaged sectors of societies, consequently, forming inequalities between social groups or demographic sectors. The study of structural violence facilitates the understanding of these, often dramatic, inequalities between social groups that can be caused or exacerbated by processes such as gender, war, terrorism or racism (Galtung 1969).

Similar to structural violence is the anthropological concept of social suffering. This is a term coined by Kleinman and is used to refer to the collective, or individual human

suffering that can be caused by conditions shaped by social influences (Kleinman 1998). Recent research about social suffering has extended knowledge about the social causes of human pain and suffering in different socio-political situations around the world (Anderson 2014; Anderson 2014b). However literature pertaining to this topic may be critiqued for its avoidance of discussion about human agency, and the complexities of the human psyche in the context of adversity.

Of perhaps more relevance to this thesis, research concerning the influence of structures on inequality identified that the most profound examples of structural violence and social suffering tend to occur in majority world countries (Kelly 1994; Scheper-Hughes 1992; Farmer 1999). Consequently, a body of literature developed that adopted the concept of structural violence in order to extend understandings of health inequalities in majority world countries. Research of this kind has primarily been conducted in order to extend knowledge about HIV and AIDS (Farmer 1999, 2005, 2006; Lane et al 2004; Greiner et al 2007; Shannon et al 2008; Fassin 2007; Agento et al 2011). However, additional topics such as substance abuse (Shannon et al 2008; Sarang et al 2010); Schizophrenia (Kelly 2005) and the health of disadvantaged women have also been better understood through use of the concept, structural violence (Mukherjee et al 2011).

Farmer's perspective on structural violence and health inequalities is of particular interest to this thesis as it addresses institutional inequalities in health systems, in the context of HIV. Farmer describes the inherent structural inequalities present in the health system of Haiti and consequences for combating the Haitian HIV pandemic. He claims that these inequalities are created by the USA through their historic, systematic exclusion of Haiti from any meaningful economic or social development opportunities and that this exclusion has resulted in poor quality health services in the country, particularly with regards to treatment for HIV, high unemployment levels and high

poverty levels. Consequently, the continued disadvantage of Haitians is guaranteed (Farmer 1999).

However, Bourgois and Scheper-Hughes argue that Farmer's perspective on structural violence may be simplistic and could be extended by the incorporation of additional conceptual ideas. Both argue that Farmer concentrates too heavily on the influence of structure, rather than exploring agency demonstrated by individuals in situations of structural disadvantage. Addressing this critique could facilitate a better appreciation of the complexities of situations of structural violence and would further avoid cliché and the inadvertent victimization of study participants (Bourgois and Scheper-Hughes 2004; Hansen et al 2014). Corbett (1994) further emphasizes how important it is to safeguard against participant victimization in research about structural violence and argues that Farmer's perspective on the topic is particularly disempowering and victimizing towards participants as he depicts Haitians as passive recipients of aid. In doing so, Corbett understands that Farmer has ignored the autonomous decision-making processes that all individuals engage in, albeit to different levels (Corbett 1994).

Still, Farmer's work provides valuable insight into the way that "good enough" local healthcare systems (Quesada et al 2011:349) create unequal societies, and draws attention to the way that polarised healthcare systems fail the poor. Farmer has emphasized how this is particularly evident in terms of the global HIV pandemic (Farmer 1999). This is despite criticism from Brucato (2011), who argues that Farmer incorrectly advocates access to Western-standard, modern health treatments for all. Brucato understands that Farmer ignores the local intricacies of health and illness, care and the global recommendation of the progressive realization of healthcare goals (Brucato 2011).

In South Africa, structural violence has been systematically enshrined into the socio-political system as a relic of the Apartheid era[2] (1948-1994) (May 2000). During Apartheid, particular policies such as the forced labour migration of black South Africans are understood to have exacerbated the consequent vulnerability and disadvantage of groups based on racial classification to HIV contraction and associated disadvantage (May 2000). The structural violence created by such policies is a legacy felt today in South Africa where significant inequalities remain. More recently, the transition to democracy in 1994, and unstable socio-political situations in neighbouring Southern African countries has resulted in an increase in international labour migrants moving to South Africa from other countries in the Southern African region. This movement of people has promoted the formation of a highly diverse, multi-national black African population in South Africa. More specifically, there have been an increased number of undocumented migrants entering South Africa in order to seek work on farms and mines (IOM 2010). Migrants of this kind are particularly vulnerable to structural violence. This situation was highly visible in the fieldwork location, and will be discussed in Chapter 5. The described increase in undocumented migrants to South Africa has resulted in debate about healthcare service access for undocumented migrants in South Africa, and the consequent impact this has had on migrant health vulnerabilities in the context of HIV (IOM 2010).

Didier Fassin's work is particularly relevant to the South African context. The author's work is mostly concerned with the intersection of structural violence with the South African HIV pandemic (Fassin 2007). In a book entitled "When Bodies Remember", Fassin delivered an impartial critique of the impact of the HIV pandemic in South Africa throughout the socio-political context of the Mbeki years (1999-2008)[3]. Fassin presented a realistic and current ethnography about HIV in South Africa as experienced

[2] The Apartheid era is discussed in further detail in chapter 3

[3] The role of Mbeki in the national response of South Africa to the HIV pandemic is discussed in chapter three, and the association of this with women's landscapes of fertility is in chapter seven.

by the black African population during this period. Importantly, the author draws attention to the extreme poverty that many suffered at this time. However, Fassin does not acknowledge or address the complex inequalities experienced by individuals within the diverse, black African population of South Africa, particularly in terms of migrants' access to primary healthcare services and facilities.

Structural violence has been used in conjunction with the phrase "landscapes" in various examples of academic scholarship, (O'Brien 2013; Mels and Mitchell 2013). It has, however, in both examples, been used as a vague metaphor for space, rather than pertaining to the original framework, as identified by Cosgrove and the New School of Cultural Geography (Milligan and Willes 2010). As such, existing research about landscapes and structural violence does not use the framework to assist with extending understandings about the intersection of structuralist and humanistic elements of a topic within a landscape.

This thesis, therefore, adopts the concept of structural violence in order to explore the structuralist elements of landscapes of fertility, in order to extend understandings about women's perspectives on and experiences of their fertility. Individual and household experiences of structural violence, and the vast negative impact that these experiences can have on personal circumstances will be appreciated in the thesis. However, the intersection of this structural violence with the exercise of individual and household agency as an interrelated dichotomy will be explored in order to extend understandings of the humanistic influences on landscapes of fertility. This conceptualisation of structural violence through study of structure and agency within landscapes of fertility will be extended through incorporation of resilience on a household and individual level as a further extension of agency as it is argued that incorporation of this concept into the landscapes framework could add value. Particularly, as Seymour and others argue that

agency and resilience are concepts that are intrinsically linked (Seymour 2012; Bohle et al 2009).

Resilience

Resilience is a concept that originates from the study of epidemiology. Within this discipline, it is defined as 'the factors that accentuate or inhibit disease and deficiency states, and the processes that underlie them' (Haggerty et al 1994:9).

Initial studies of resilience focused on extending understandings of disease factor resilience (Luthar 1991). Gradually, however, the concept was incorporated into the discipline of developmental psychology. It was understood that resilience could be used to extend understandings of the complexities of human consciousness, rather than purely physical, biomedical health and disease. Study of psychological theory has indicated that resilience can be understood as "the potential to create opportunities for doing new things, for innovation and development", whether on a personal scale, or at a community or institutional level (Ager 2006: 253).

Bohle and colleagues (2009) argue that reconceptualisation of resilience *as* personal agency may extend knowledge. However, Seymour and others claim that a certain level of resilience is needed in order to capacitate an individual to express agency when needed (Seymour 2012). Therefore, resilience and agency can be understood to be intrinsically related to each other, yet not the same thing, as one facilitates the production of another. Resilience has been used to explain, amongst others, the strategies for survival in various situations of poverty (Bohle et al 2009; Eggerman and Panter-Brick 2010; Zraly et al 2010), and disaster management (Almedom 2007; Ilagan 2014), as well as the cognitive development of children from difficult backgrounds (Dawes 1990; Bandura 2001) and post traumatic stress disorder (PTSD) (Almedom and

Glandon 2007; Levine et al 2009). However, the concept of resilience has been criticised for not being theoretically robust enough to have any value, as studies to date have concentrated on empirical contributions rather than the use of resilience in any theoretically contribution to knowledge of significance (Rigsby 1994; Kaplan 2013).

This thesis, therefore, adopts the concept of resilience within landscapes of fertility. Resilience is interpreted in this thesis as an expression of personal agency at both individual and household level. Consequently, the manner through which individuals and households are able to exercise agency in order to negotiate situations of structural violence, will be explored.

The concepts of structure, agency and resilience are developed within the landscapes framework as prescribed by Cosgrove in order to extend understandings of the structuralist and humanistic components of landscapes of fertility. This will be achieved through exploration of the structural violence, agency and resilience as an expression of individual agency within landscapes of fertility. As a consequence, new knowledge about the complex intersection of structure, agency and resilience within landscapes of fertility could be developed.

Section Conclusion

Structural violence is a concept that has provided a valuable insight into the health inequalities present in majority world countries, particularly in the context of HIV (Farmer 1999; 2005; 2006, Fassin 2007). It has been demonstrated that structural violence is concerned with the societal, cultural and institutional structures that systematically prevent individuals from the most disadvantaged groups in a society from achieving their full potential. However, as research about structural violence has focused on the negative impact that structures can have on the lives of individuals, it

can be argued that the concept has failed to acknowledge the personal agency that is exercised by individual actors, even within the constraints of the impeding structures present in the situations of structural violence (Scheper-Hughes 2008). Individual actors demonstrate some level of agency in even the most structurally inhibitive situations, which facilitates the negotiation of obstacles when achieving daily needs. Thus knowledge could be extended by incorporation of study of the agency of individuals in extreme adversity as well as an understanding of the resilience of individuals (Seymour 2012).

In this thesis, structural violence, agency and resilience will be studied as intersecting dimensions of landscapes of fertility. Thus, new understandings about the complex intersection of structuralist and humanistic influences within the developed landscapes can be extended.

This thesis will adopt migration as a further dimension within landscapes of fertility and as a contextual factor influencing fertility preferences.

1.4 Migration

This thesis incorporates migration as a dimension of landscapes of fertility, as this research is located within a rural area of South Africa where there is long history of migration. As a consequence, migration has a significant impact on women's landscapes of fertility. It is also a contextual factor influencing fertility preferences and is a product of agency and resilience as well as a being product of structural violence.

Migration is the movement of people from one place to another. It can be a forced or voluntary movement, and is stimulated by push and pull factors. Migration can occur for many reasons, such as: poor environmental conditions in the home country, the

previous movement of family, famine, war, (un)employment and many others. Migration has occurred in regions for many centuries and has "'always been part of human endeavour" (Haour-Knipe 2009:27). Of particular relevance to this thesis, migration has been studied in conjunction with structural violence, gender and HIV.

Structural violence and migration

Historically, migration played an integral part in the shaping of personal identities, as the passage of migrants and experiences of migration is understood to contribute to identity development, as does the anticipated potential for mobility (Haour-Knipe and Rector 1996). However, this natural movement of people is today restricted by state sovereignty and border control (IOM 2010). Despite these new levels of control, migration, particularly that undertaken for labour purposes has increased throughout the world over recent years. With this increased movement of people, there are also large numbers of people who migrate without visas and passports. These people are known as undocumented migrants and tend to be subjected to high levels of disadvantage that is often structurally reinforced by the host countries resulting in the creation of situations of structural violence.

In South Africa, however, the constitution enshrines migrant rights as natural rights. Civil, political, social, cultural and economic rights are extended therefore to include the needs of migrants, regardless of citizenship. The constitution allows for access to essential services such as health care, *for all*, rather than allocation in terms of citizenship (South African Constitution: Chapter 2; South African Constitution Article 27.1.a). Despite these allowances, the exercise of the constitutional guidelines in the country is not always in accordance with the law, thus creating unconstitutional disadvantage for undocumented migrants and, in many cases, subjecting them to structural disadvantage or violence (IOM 2010).

Research addressing migration and structural violence has mostly extended knowledge about the health (and other) inequalities experienced by undocumented migrant workers in the USA (Queseda et al 2011; Ordonez 2012; Holmes 2011). Whilst knowledge has been extended about the personal experiences of inequality of these undocumented migrant workers, scholars such as Scheper-Hughes argue that studies of this kind have failed to acknowledge the agency of actors within situations of structural violence (Scheper-Hughes 2008).

This thesis, therefore, explores the intersection of migration and structural violence, agency and resilience as elements of landscapes of fertility.

Migration, gender and the association with HIV

Research on migration intersects with gender studies. Historically, migration was conceptualized as a male process that was disempowering towards women. Men were conceptualized as primary migrants, or migratory leaders with their wives or partners as secondary, migratory followers (Morokvasic 1984). Alternatively, it was proposed that women stayed behind in the home community whilst the men migrated alone (ibid.). It is, however, argued that this early conceptualization of the process of migration was gender blind, and ignored the migration of women independent of their male partners (Morokvasic 1984). As a consequence, Morokvasic inspired the study of migration in collaboration with gender studies, which led to the conceptualization of, particularly younger, women as empowered migratory leaders, or "birds of passage" (Morokvasic 1984; 1986). Through this reconceptualisation, it was accepted that women as well as men can be independent labour migrants. Consequently, it is argued that Morokvasic's contribution to literature on migration stimulated a pivotal shift in the study of gendered migration (Botteril and Janes pers comms 2013).

The historical context of migration in South Africa fits within this early paradigm. During the Apartheid years (1948-1994) the local migrant labour system was institutionalised, and subsequently meant that black African residents lived in situations of structural violence. This institutionalised migrant labour system was a corner-stone of separate living in the country. Black African people lived in rural Bantustans (for more detail see chapter two, which is about the setting of this research), and applied for passes to reside in designated black African areas that were adjacent to employment opportunities. The majority of accommodation provided close to employment was located on marginal land surrounding cities and towns, or on the edge of farms or mines. This accommodation was single sex, for men only. Women who worked away from the Bantustan were often provided with some sort of basic accommodation at the place of work, which was usually a clinic, school, or in the grounds of a private white-owned residence. However, in reality some families migrated away from the Bantustans to live illegally with their working family member. These were usually women who were, consequently, migratory followers of their male partners. These female migratory followers stayed illegally and with constant fear of arrest in overcrowded accommodation meant for single men, on burgeoning informal settlements on the edge of formally designated black African residential areas, known as townships (Dubow 1992; Ngcobo 1990).

More recent research about gender and migration has addressed women's roles as empowered agents of migration and the gendered flows of people between and within countries (Boyle and Halfacree, 1999; Kofman et al., 2000; Pessar and Mahler, 2006; Piper, 2005; Pratt and Yeoh, 2003; Raghuram, 2004). However, it can be argued that this body of literature simplifies migration to its most basic level (Haour-Knipe 2006). As a consequence, it has since been acknowledged that the process of migration is far more complex than Morokvasic and others understood. More recent scholarship has

suggested that rather than migration affecting the migrant individuals only, it should rather be conceptualized as a "family affair" as all members of the migrant(s) household can be impacted by the movement (Haour-Knipe 2009).

Thus, migration is now understood to be a process located within the household. Scholarship about this topic has concentrated on study of overseas retirement, where older retirees follow children who have previously moved overseas (Williams et al 2000; Williams and Hall 2000). However, these studies have been located within the context of economic affluence and retirement, where the migrants' home country is an economically affluent country, and the host country either a majority world country (for example, South Africa, Jamaica) or an economically affluent country in the Southern hemisphere.

The conceptualization of migration as an intergenerational phenomenon has been used to extend knowledge about the HIV pandemic in majority world countries (Berk et al 2003; Harris et al 2005; Clark et al 2007; Knodel and van Landingham 2003; Schatz 2007; Sengozi 2007). In particular, five studies, two of which were conducted in South Africa, identified that labour migrants who contract HIV whilst in the host country are likely to return to their families for care and support at the end of their lives. Thus, in circumstances of this kind, the whole family and household are involved in the migratory process (Haour-Knipe 2009).

This research will, therefore, explore intergenerational patterns of migration in the context of the need for care, as caused by the HIV pandemic (the South African experience of HIV is discussed further in section 2.2). Due to the nature of the HIV pandemic, this could extend understandings of migration and the household in the context of majority world countries that is relevant to women's landscapes of fertility.

Section Conclusion

It has been demonstrated that understandings of the process of migration that are of relevance to this thesis have addressed the interrelation of the concept with structural violence, resilience, HIV and fertility preferences. This thesis will extend current debate about migration associated with the household by exploring the role of intergenerational migration within the household and its intersection with landscapes of fertility.

1.5 Conclusion: Locating the conceptual framework of this thesis within current literature

This chapter has positioned the thesis within current literature on fertility; landscapes pes; structural violence, agency and resilience; and migration. This research will make an original contribution to knowledge through the study of fertility preferences as one aspect of landscapes of fertility. In doing so, the landscapes framework will be adopted, in its true form as a "way of seeing", as prescribed by Cosgrove and the New School of Cultural Geographers. Landscapes of fertility will be explored through incorporation of the concept, structural violence, in order to facilitate explanation of the structuralist elements of the landscape. In this thesis, the structuralist elements of landscapes of fertility will be explored, alongside humanistic influences of these landscapes. In a further extension of current scholarship pertaining to structural violence, and to extend knowledge about the humanistic elements of women's landscapes of fertility, the personal agency and individual resilience displayed by women in the context of their fertility will be explored. This incorporation will consequently facilitate a study of the complexity of the intersection of various concepts on women's landscapes of fertility and their intersection. This thesis will further adopt the African Femininity Perspective within the research design in order to explore fertility preferences as an aspect of

landscapes of fertility in a gender sensitive, non-exclusionary manner that is relevant to the local context. This critical review of literature pertaining to fertility; landscapes ; structural violence, agency and resilience and migration has identified a number of gaps in current research. These are addressed in this thesis through a mixed method sequential exploratory research design in order to answer the following research questions:

1. What are women's intergenerational understandings of landscapes of fertility within the context of the changing socio-economic context of rural South Africa?
2. How do patterns of migration intersect with women's landscapes of fertility?
3. To what extent does the HIV/AIDS pandemic in South Africa contribute to women's landscapes of fertility?

These research questions will be addressed in Chapters Four to Six respectively. The following Chapter Two presents a discussion of the setting of this research.

Chapter 2: Setting

2.1 Introduction

This chapter gives an overview of the setting of this research. The first section of the chapter presents the context of South Africa and how this has influenced experiences of structural violence, migration and HIV across generations. The second section of this chapter discusses the geographic and socio-economic setting of Khaya'manzi, which is where fieldwork took place for this doctoral thesis.

2.2 South Africa

South Africa is the Southern-most country in the African continent. It is surrounded by the Atlantic Ocean on the Western side, and the Indian Ocean on the East, giving rise to a highly varied physical environment. South Africa is 1.2 million square kilometres in size and is divided into nine provinces, each with a unique geographical and socio-cultural profile (Gramfors et al 1996). The country shares international borders with Namibia, Botswana, Zimbabwe, Mozambique and Swaziland and surrounds the land-locked country Lesotho (See figure 2.1 for a map of South Africa). South Africa's location and close proximity to other Southern African countries has resulted in a long history of international migratory movement that has influenced the varied demography of the country. Indeed, this migration to and within South Africa predates the drawing of the colonial boundaries that designated borders between the Southern African countries. Prior to colonial influence, tribal affiliations and nomadic movement extended across these later externally imposed borders (Feinstein 2005).

Figure 2.1 Map of South Africa showing provinces. Adapted from www.sageogs.org

The demographic composition of the South African population is diverse and, reflects these historic migratory flows. Out of a total population of 51.77 million (Statistics South Africa 2011), black African[4] are the majority, making up 79.2% of the population (ibid), coloured and white groups each make up 8.9% of the total population and Asian/Indian 2.5% (ibid). Broadly, the Black African demographic is descendant from four ancestral groupings: the Nguni, Sotho-Tswana, Tsonga and Venda. White South Africans mainly include people of Dutch, French, German and British descendants. Much of the Indian population descend from enslaved migrants from colonial India, and the coloured sector comprises people of mixed racial heritage (Feinstein 2005). It can be acknowledged, therefore, that the socio-cultural and demographic composition of the country is highly diverse, and formal recognition of eleven official languages reflects this.

[4] Race and racial categorisation remains a contentious issue in South Africa, and the term 'race' is a problematic construct. This thesis, however, adopts the official terms for racial categorisations as specified by Statistics South Africa (available at http://www.statssa.gov.za). This debate is discussed in further detail in chapter 3.

South Africa is a country with a complex political and socio-cultural history that has been categorized by conflict and discontent, within which black African residents have been subjected to ongoing situations of structural violence. Archaeological evidence demonstrates that South Africa was the location of some of the first discovered human settlements (Thompson 2001). From this it can be understood that the first recorded demographic group of South Africa was the Khoisan who lived in the Southern parts of the Cape (Vossen 1984). In the mid 17th Century, the first threat to the survival of this group arrived in the form of ninety Europeans from the Dutch East India Company led by Jan van Riebeeck. They landed at the Cape of Good Hope (now Cape Town) in order to build a fort and cultivate a vegetable garden for use by the crews of ships that stopped there on route to Asia (Feinstein 2005). This was the first European colonization of the country.

Initially, the Dutch colonials and the indigenous Khoisan had a mutual trade-based relationship, but tensions developed due to cattle theft, the devastating consequences of imported diseases such as smallpox and the perceived threat to the Khoisan posed by the fast expanding Dutch population resident at the outpost (Marks 1972). In 1657, nine men from the outpost were allocated land to farm, and the first slaves imported to the area, which resulted in the construction of the first colony of South Africa, which increased in number to 250 people in 1662. The Dutch government encouraged immigration to the colony, and as a result, the Khoisan were forced by necessity of circumstance to work for the settlers, lost land, and were affected by imported diseases (ibid). Their ancestors became the later classified "coloured" population of the country.

The Dutch retained colonial rule over South Africa until 1795 when the British won control of the Cape colony in order to protect the only available sea route to Asia. Seven years later it was returned to Dutch rule, but in 1806, the British conquered the colony for the second time (Feinstein 2005). The British methods of governance caused

conflict with the Dutch settlers (Boer), and in 1834, the Boer began migrating (the *Great Trek* (Afrikaans for *journey*)) to the interior of the country, away from the coast, in protest against and rejection of British rule. As a result of their migration inland, the Boer found themselves landless and without security or food. Consequently, they forcibly occupied tribal land for their own use and created conflict with the black Africans they displaced. The Boer later established the Transvaal and Orange Free State as independent states that were outside of British colonial governance (Giliomee 2003). These areas are today part of the Republic of South Africa but are still areas known for their strong Afrikaaner heritage.

During the same period of time, Shaka Zulu the prominent Zulu warrior and later King rose to power in the eastern area of the country. The British had stationed an outpost here, and were developing a colonial settlement (Hamilton 1989). The Zulu population had previously migrated to the area, as part of the Bantu Migration in about the ninth century. The Zulu came from parts of East and central Africa, and had, over the centuries gradually developed and expanded a Kingdom in part of what is now KwaZulu-Natal province. Under the rule of Shaka Zulu, this Kingdom had expanded in size and power (ibid). The British came into conflict with the Zulus, as they wanted access to the Zulu people for labour purposes, and also wished to incorporate Zulu land into the colony through the development of a South African Federation. In 1879 the British eventually defeated the Zulus and gained both land and labour. After which black Africans of Zulu ethnic origin were subjected to ongoing human rights abuses and disadvantage, which had a knock on effect of disadvantage through generations (Laband 1992).

This conflict was followed by the first Anglo-Boer War, which took place between 1880 and 1881, debatably in response to the aspirations of the fourth Earl of Carnarvon to form a confederation of all British colonies which conflicted with the Boer ideology

and resulted in an increasing opposition of the Boer to the methods of the British rule (Giliomee 2003). Again, the British were successful, and as a result, the Pretoria convention of 1881 and the London convention of 1884 were formed in an official peace treaty between the British and the Boer. This peaceful nation lasted for around a decade, after which the two countries were involved in a power struggle surrounding the attempted expansion of the Boer from the Orange Free State and the Transvaal into the more Northern areas of the country. As a result of this heightened state of conflict, the second Anglo-Boer war started in 1899, and culminated in 1902 (Giliomee 2003).

In 1910, the South Africa act was passed, and the union of South Africa established. The British proposed ideological compromise with the Boer, and as a result of collaboration between the two nations, various acts were passed that paved the way for the later development and official implementation of the Apartheid laws, which were discriminatory against black African, Indian and Coloured people, and provided foundation for the disadvantage and structural violence suffered by non-white residents of South African today (Lipton 1986). Key legislation included the Mines and Works Act (1911), which prohibited black African people from receiving skilled employment opportunities; The Natives Land Act (1923) regulated the acquisition of land by black African people; the Natives Affairs Act (1920) allowed for a system of traditional councils and chiefs, the Natives (urban areas) Act (1923) restricted the movement of black Africans between rural and urban areas and the 1936 Native's Trust and Land Act (also known as the Bantu Trust and Land Act). Under this act, black Africans were relocated into zones called Bantustans and forced to live in these areas unless in possession of a work contract and a pass book that enabled them to move between the Bantustan and area of economic activity (Feinstein 2005). The passing of these acts, amongst others were the start of the separation of South Africans by race, and paved the way to the eventual, official implementation of Apartheid policy, and the subsequent structural violence created by racially discriminatory legislation.

The later, Apartheid (racially separate), living arrangements in South Africa stemmed from implementation of policies such as these described above, and the manifestation of racially separate living that was first promoted and implemented by the British in Cape Town in 1928. In the 1920s, Cape Town, which was under colonial rule, was rapidly expanding and becoming more affluent and prosperous. The colonial British ruling party made the decision to move indigenous people to a location outside of the growing colonial city to stem fears over the potential public health problems that could be caused by racial mixing (Lipton 1986).

Conflict and ideological clashes between the colonial British and Dutch continued and in 1948, the National Party came to power (the electorate being formed only of people classified as white). Initially the main aims of the party, led by DF Malan, were restriction of British influence to the country, and the restructure of immigration policies in order to restrict British migration to South Africa (Feinstein 2005). Malan put politicians of Afrikaner origin in prime political positions in the cabinet, and therefore ensured that Afrikaner ideology was dominant in parliament (Lipton 1986). As an election policy, Malan had coined the term "Apartheid" and once the national party was in government and restrictions were in place against the British, the party turned their attention to the implementation of the Apartheid laws that were to be discriminatory against black African, Indian and coloured residents, and resulted in the situations of disadvantage experienced, particularly by black African residents of South Africa to this day (Clark et al 2004).

The Apartheid ideology was enforced between 1948 and 1994. During this period, legislation strictly enforced the imposed "separateness" of living experienced by South Africans of different racial characteristics. According to the race classification act, it was required that all residents were assessed and consequently classified according to

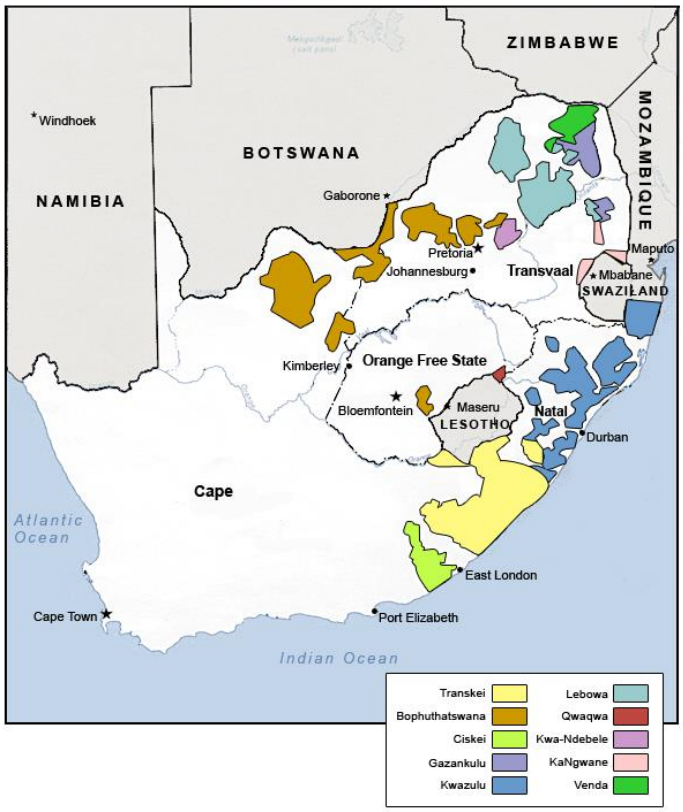
their determined race. The criteria used to categorize an individual were complex, and consisted of a number of "pseudo-scientific tests" (Dubow 1992:214) that located an individual within one of four racial groups (black, white, Indian or coloured). Individuals had to undergo the classification process on an annual basis and were sometimes reclassified into a different racial group. Criteria used to determine the racial group of an individual included the curliness of hair determined by the pencil test and the size of the individual's nose. Other criteria taken into account included racial classification of the individual's friends and acquaintances, and languages spoken (ibid).

The racial group a person was assigned to would determine their future opportunities as well as their quality of life. The 'black' demographic were the lowest in the system, understood by some people to be of less value than dogs (May 2000). They had no formal representation in the national government. The 'coloured' (mixed-origin) and 'Indian' sectors of the population were also discriminated against, but in the latter years of Apartheid had a small representation in separate houses of national government and the 'white' population sector which comprised the governing party and was acknowledged to be superior to all other demographic groups (Giliomee 2003).

The segregation of different racially designated groups dictated by Apartheid legislation was evident in all areas of life. For example, living areas for different racial groups were separate, with every town segregated into neighbourhoods categorized by race. "Black" residents had to adhere to a curfew and were severely punished if this was breached (Giliomee 2003). Public, recreational and shopping facilities were separated, with, for example, separate buses for "black" and "white" people and different entrances and waiting areas in public buildings for people of different racial categorization (May 2000).

The country itself was divided by race into regions: there were four "white" provinces and nine Bantustans. Figure 2.2 demonstrates the location of these. Bantustans served as "dumping grounds" (Ngcobo 1990:43) for the unemployed, women and children, disabled and sick, whilst men were forced to move to the black urban areas when employment was available to them (May 2000). This system of enforced labour migration "destroy[ed] family life… [and] when our men moved to the cities, we lost our culture and our stability" (Ngcobo 1990:81). Later, this system also had negative repercussions for the health of the back African population of the country, as this Apartheid policy of forced labour migration is now understood to be a prominent cause of the spread of the HIV pandemic in the country, and the subsequent health-related inequalities characteristic of South Africa (Coffee et al 2007).

Figure 2.2 Map Showing Bantustans. Adapted from Matrix (1984)



Bantustans, were known formerly as 'homelands' and recognized by South Africa as independent state, were controlled by tribal chiefs, who were government-appointed individuals from within the community. A chief ruled his Bantustan under the regulations prescribed in the native affairs act of 1920. Chiefs have been described as "puppets of the regime" as they were in control of access to resources for the Bantustan and therefore were responsible for the quality of living of Bantustan residents (Ngcobo 1990: 205). However, not all chiefs were fair and governed honestly, and this meant that quality of living varied between regions. This inequality has contributed to the inequality present within racial groups in South Africa that is still evident today. Many tribal chiefs were also informants to the Apartheid regime, allegedly forced to report to officials about illegal behaviour within their area, resulting in the arrest of many Black Africans (May 2000). One such chief, famous for his divided loyalties was Mangosutho Buthelezi. Buthelezi founded the Inkatha Freedom Party (IFP) and is still the leader and sits in opposition to the national ruling political party, the African National Congress (ANC). During Apartheid, he was chief of the KwaZulu Bantustan and notoriously opposed the anti-apartheid movement, because his livelihood and financial circumstances depended on the success of the regime. His seemingly divided loyalties led, in part, to the violence and unrest between his supporters and ANC supporters in the 1980s (Mare and Hamilton 1987).

Of particular relevance to this thesis, during Apartheid, "public health [was] used as a tool of oppression" (Lengwe Kunda and Tomaselli 2012:111). The quality of healthcare services available to Black Africans was inferior to those accessed by white South Africans (Marks and Andersson 1987). Whilst Bantustans were equipped with clinics, these were poorly resourced and mostly staffed by nurses with elementary training only. Antenatal care was of poor quality, and many women died in childbirth (Ngcobo 1990). Very few black Africans were permitted to train as doctors, in order to seek employment in black African designated healthcare facilities and as such, quality

healthcare facilities were seldom available in black areas (Cook and Kalu 2008). Experimental regime policies focused on white population expansion, and black population restriction, which meant that many black women were victims of forced or coerced sterilization as well as other unauthorized medical procedures. These often occurred whilst they were giving birth at a Bantustan clinic (May 2000).

As a consequence of this discriminatory and divisive national legislation, Black Africans were born into situations of extreme disadvantage, and were "systematically deprived of their futures", the effects of which are still evident today, as many, particularly, black African residents of the country are still affected by structural violence that has passed through generations (Ngcobo 1990:272).

The Apartheid era ended in 1994, after a political struggle between the African National Congress (ANC) and the National Party. The struggle was initially sparked by rebellion of the black working class categorized by township unrest and mine workers strikes throughout the 1940's and 1950's (Clark and Worger 2004). Protest occurred in response to escalating living costs, aggressive enforcement of pass laws, enforced education in the Afrikaans language and liquor laws and other commercially discriminatory laws (Dubow 1992). Pass laws required Black Africans to carry identity documents with them at all times. These were used to control and restrict the movement of "non-white" residents (ibid).

In 1960, at the Sharpeville massacre, 300 police opened fire on demonstrators, killed 69 and injured 189 involved in a protest against the carrying of passbooks. This galvanised the formation, in 1961, of the military wing of the ANC (Umkhonto weSizwe) (Gordin 2008). Umkhonto weSizwe operated "underground" and from exile for the duration of the struggle, raising the profile of the ideological clashes and influencing the government to twice declare the country in a state of emergency (Motumi 1994).

From the 1960's, the mass politicization of Black Africans resulted in regular protests and demonstrations against aspects of the regime, until the release of Nelson Mandela from prison in 1990 and the initial negotiations for democracy which eventually resulted in a negotiated transition to democracy (Dubow 1992). This internal struggle took place alongside an international campaign involving economic sanctions and cultural and sporting boycotts. A democratic government was formed in the country and the Nobel Peace prize awarded jointly to Nelson Mandela, the incoming president for the ANC, and FW De Klerk, the outgoing president who worked together to successfully negotiate the transition to democracy culminating with the first democratic elections in the country in 1994 (Clark and Worger 2004). International governments and global organisations heavily supported South Africa's transition to democracy. However, the role of these external bodies within the transition process has been critiqued, particularly in terms of manipulation of new neo-liberal economic policies, which run counter to the historical ANC policies (Marais 2001).

Since 1994, the ANC has aimed to unite the historically racially segregated society of South Africa in the construction of the 'Rainbow Nation': a term coined by the anti-apartheid activist Archbishop Desmond Tutu. Now, attempts are being made to redress the structural violence and damage caused by the discriminatory policies implemented during Apartheid. Initially, this was formally achieved through the Reconstruction and Development Plan (RDP), Truth and Reconciliation Commission (TRC) and initiatives such as land reclamation and Black Economic Empowerment policies (BEE) (Tangri 2008).

The Reconstruction and Development Programme (RDP) was an initial economic and social development programme that aimed to provide infrastructure to previously disadvantaged communities in South Africa as part of stabilising and promoting

development in the new, post 1994 democracy. Major development initiatives within the RDP included housing supply, electricity and water services, roads development, healthcare, education, job creation, land reform and community building in geographical areas of South Africa that were home to the black African population (Tangri 2008). The RDP was founded on the ANC (in coalition with the Communist Party) 1955 Freedom Charter and had great critical acclaim. This is due to the facilities and amenities it afforded communities, as well as homes and services for predominantly black African South Africans from previously disadvantaged backgrounds (May 2000).

Despite the benefits the RDP afforded black South Africans, there was still an identified need to integrate this previously disenfranchised and oppressed demographic group into the economy. As a response to this, the Growth, Employment and Redistribution (GEAR) macroeconomic plan, a subsequent five-year economic programme, was devised and implemented from 1996. GEAR aimed to succeed the success of the RDP, but was seen to follow a more neo-liberal programme focused on privatisation, job creation and integration of previously disadvantaged groups into the economy (Tangri 2008). GEAR lowered budget deficit and inflation in the country, but has been criticised, particularly by the Congress of South African Trade Unions (COSATU), for failing to deliver on job creation, income redistribution and economic growth (ibid.).

A second initiative that was developed in order to promote growth and reconciliation in the early years of democracy was the Truth and Reconciliation Commission (TRC). The TRC was seen as an opportunity to encourage the reunion of South Africans of different race and to assist all to "come to terms" with the atrocities committed on all sides during the Apartheid era (Wilson 2001:52). The TRC had three divisions: the Human Rights Violation Committee (HRV) whose aim was to investigate human rights abuse claims, and identify victims and outcomes. Victims, or victims' families were then referred to the Repatriation and Rehabilitation Committee (R&R) for rehabilitation

of survivors and families of victims. Finally, the Amnesty Committee (AC) considered applications for amnesty of perpetrators, and gave those who admitted to crimes an opportunity to tell their story. If amnesty was granted, the perpetrator was then free from prosecution for their crime (ibid). In spite of shortcomings, such as the concentration on individual amnesty within the TRC, which meant that the atrocities committed by the Apartheid system as a whole were largely ignored, the TRC was seen as a positive event that assisted South Africans with nation building and certified commitment to build a better society, whilst providing atonement to those who require it. TRC's have since been implemented in various situations to atone for past atrocities, most famously in Kenya, Liberia and Uganda (Zehr 2002).

Land reclamation is a process through which the newly elected democratic government aimed to redress inequalities and subsequent situations of structural violence and disadvantage caused by land displacement policies during Apartheid. The land reclamation process targeted, in particular, the natives land act of 1913. The land reclaim act passed in 1996 enabled those who had been forcibly removed from their property during the Apartheid regime to reclaim their ancestral land, in a move to restore Black African land ownership to stimulate participation in the lucrative agricultural and residential sectors (James 2007). This was understood to be a relatively fair process, as the landowner was offered market value for the property in order for it to be returned to the original owner. This process, however, has been controversial due to the length of time taken to process claims, and the lack of support for claimants once land has been re-allocated (ibid).

A further significant initiative aimed at encouraging the participation of previously disadvantaged groups in the labour market, and therefore accelerating their economic integrity is the Black Economic Empowerment (BEE) policy. BEE is concerned with "the broader and meaningful participation in the economy by black people to achieve

sustainable development and prosperity" (BEE commission report 2001: 2). BEE policies have come under criticism by some, however, for encouraging "reverse-racism" and creating a climate of expectation, particularly in younger generations (Carter and May 2001).

Despite politically championed state initiatives of this kind, the legacy of Apartheid legislation is still felt today in South Africa, as black Africans are still the poorest in the country (May 2000). According to the Gini index, South Africa is still a highly unequal society, with a coefficient of 63.1 in 2009 (World Bank 2009). There are ongoing inequalities in education, health, utilities, housing, safety and employment. However, despite overall levels of inequality remaining static, increasingly, income inequalities are present within rather than, as previously, between racial groups. This could be explained by the emergence of the black African middle classes, and this demographic group embracing all the amenities, opportunities and lifestyle choices associated with increasing levels of modernity in South Africa (Kotze et al 2013).

Also present today is a strong socio-spatial inheritance from the Apartheid era as South Africa still predominantly comprises racially segregated residential settlements. The residential segregation implemented during Apartheid resulted in the development of strong community ties and neighbourly bonds within residential areas. As a consequence, many families were unwilling to move away from communities, friends and family once Apartheid ended and restrictions were lifted (Carter and May 2001). Today, this socially reinforced residential segregation is considered by some as an obstacle affecting the racial integration needed for true social progress (ibid.).

More recently, South Africa has experienced challenges caused by the global HIV/AIDS pandemic, with the Black African population being the most infected and affected (Lengwe Kunda and Tomaselli 2012). Accurate data regarding up to date,

correct, infection levels is difficult to come by, as health surveys have come under criticism for mis-classification of patient illness and cause of death (Statistics South Africa 2010). However, overall national infection levels are estimated to stand at an average of 10.5% (Statistics South Africa 2010). However, in KwaZulu-Natal province in particular it has been suggested that as many as 50% of women of reproductive age could be HIV positive (Welz et al 2007). In 2007, it was further determined that South Africa bore the burden caused by one sixth of the global total of HIV infections (Parker 2012).

Multiple, complex reasons have been suggested to explain South Africa's high infection rates and the corresponding knock-on effects of the disease. These include: large levels of labour migration, as institutionalized by the Apartheid regime (Coffee et al 2007); global policies that do not take into account regional variation (Parker 2012); polygamous behaviour (Mottiar 2012) and inequality and marginalization, relevant to the structural violence created towards black South Africans as a manifestation of Apartheid era disadvantage (Parker 2012). Most importantly, however, is perhaps the suggested failure of South Africa's government to tackle the issue in a timely manner, and which has resulted in "top-down confusion" over how to deal with the pandemic (May 2000: 65). It has even been suggested, "South Africa has represented the epitome of disastrous national responses to Africa's HIV/AIDS pandemic" (Lengwe Kunda and Tomaselli 2012).

In the early 1990s, the first post Apartheid government implemented what was described as a disorganized and chaotic response to the disease, leaving HIV positive individuals without support and with few opportunities to access the medication and care that they required. This was, however, followed by the "outright denialism" of the successive cabinet, led by then president Thabo Mbeki and minister for health Tshabalala Msimang (Sheckels 2004: 28). Mbeki was said to believe that HIV did not

cause AIDS, and implemented policies that supported this understanding (ibid.). Under Mbeki and Msimang, anti-retroviral (ART) treatment roll out to government health facilities was delayed and rationed, post mother to child transmission therapy (PMTCT) unobtainable and garlic, beetroot and other alternative therapies advocated as an unproven treatment against infection (Lengwe Kunda and Tomaselli 2012). There were few, if any programmes that provided information about HIV prevention to vulnerable population groups. As a result, in 2005, more than 5 million South Africans were living with HIV and had little access to treatment and care. At that point, South Africa had the highest HIV rates in the world (ibid.).

The attitude of government towards tackling this pandemic was felt in combination at this time with legal battles between African governments and pharmaceutical companies concerning the inflated costs of ART medication (Lengwe Kunda and Tomaselli 2012). As such, mostly economically disadvantaged black South Africans were deprived access to the medication they required, and this resulted in many untimely deaths from advanced stages of AIDS (Parker 2012).

In 2006, further impediments to progress against the disease were experienced by actions of others from the cabinet. In 2006, the then Deputy President, Jacob Zuma, now President, was accused of having non-consensual, unprotected sex with "Khwezi", an HIV positive, Swazi woman he had invited to his home in Johannesburg. Whilst Zuma was found not guilty of rape, he infamously claimed that "he dealt with her HIV status, there not having been a condom available at the critical moment, by having a shower immediately afterwards" (Gordin 2008:165). This was an example of how political leaders failed to acknowledge the disease and failed to engage in public health campaigns crucial for addressing the pandemic (Parker 2012).

Alongside the confusion about HIV present at political level, education and awareness interventions aimed at reducing the spread of HIV were initially difficult to implement and had a low uptake throughout the Black African demographic of South Africa (May 2000). This was in part due to previous experience during the Apartheid era, where public health policy was used as a tool of oppression (Lengwe Kunda and Tomaselli 2012). As such, there was widespread perception that this then newly identified and highly visible disease, HIV, was yet another systematic attempt to oppress the non-white population of the country (Parker 2012). This fear was predominantly manifested in the reluctance of particularly Black African males to adhere to guidance concerning infection risk through unprotected sex and "condomising", as it was widely perceived that the advocated use of condoms was a "white man's method of Black African population control" (May 2000: 64).

As a consequence, the HIV pandemic has had a major impact on economics, healthcare and investment in South Africa and regional demography has been affected (Ramjee and Gouws 2002; Eaton et al 2003; Pettifor et al 2005; Dunkle et al 2006; Welz et al 2007; Taylor et al 2009). More recently, however, top down incentives and politically-driven initiatives have been implemented to attempt to address the negative ramifications the disease has had on the black African demographic and the country at large. Importantly, due to a change in cabinet, the government has been able to implement various policies and incentives that have addressed the impact of the disease on the black African population of the country (May 2000).

In 2008, there was a government reshuffle. The new Minister for Health, Barbara Hogan instigated a new approach to HIV following "almost a decade of denial and neglect" (Lengwe Kunda and Tomaselli 2012). This progress was continued and expanded upon by minister for heath under president Zuma, Aaron Motsoaledi, who was appointed in 2010, and is still in the role at the time of writing. Motsoaledi made

ARV and PMTCT medication widely available to all through distribution at primary healthcare clinics, launched top down HIV awareness programmes, promoted the uptake of HIV voluntary counseling and testing services (VCT). The implementation of these policies and programmes reduced new HIV infection levels drastically and it has been said that Motsoaledi "single-handedly improved the health of the black population of the country" (Lengwe Kunda and Tomaselli 2012). In 2013, Motsoaledi personally administered the first dose of a new combination single pill ARV therapy to a state patient, launching the role out of this new ARV drug that would change the lives of millions (ibid.).

Despite these more recent improvements in services for HIV and access to treatment the widespread reach of the HIV pandemic, coupled with the poor and incompetent, initial, national response to the disease resulted in the reduction of lifespan and untimely death of many black Africans in South Africa. Consequently, there has been an increase in the numbers of orphans and vulnerable children (OVCs) within communities across the country (Campbell et al 2009). As a response to this increase in vulnerable children, the government mobilised funds to form community crèches and day care facilities. These were to provide care, education and nutrition for OVCs as well as develop informal networks of support that correspond with black African socio-cultural norms surrounding child care in communities (Campbell et al 2009). These care facilities are present and visible throughout the fieldwork location: Khaya'manzi.

2.3 Fieldwork location

The fieldwork for this doctoral thesis was conducted in a community, which for the purpose of this thesis is called Khaya'manzi, located in KwaZulu-Natal province, north of eThekweni (previously Durban) and in the direction of established migratory

pathways between Swaziland and Mozambique. Figure 2.3 displays South Africa's location in relation to neighbouring countries.

Figure 2.3, South Africa in relation to neighbouring countries. Adapted from www.sageogs.org

The population of Khaya'manzi is predominantly black African and the residents of the community live in relatively disadvantaged conditions. The most recent population estimate was around 63,000 in 2002. Unemployment levels in Khaya'Manzi reflect national, high, (25.2%) unemployment levels (Stats SA 2014). The majority of black African households in Khaya'Manzi have an estimated income of less than ZAR1,500[5] per month, despite newly enforced minimum wage legislation for labourers and domestic workers. This is lower than the national average for the population group, which is at R2167 per household per month (Stats SA 2010). Some Khaya'Manzi residents are employed in the agricultural sector and earn less than the minimum hourly wage of ZAR 11.66. Others work in the tourism sector in a nearby town or as domestic workers or gardeners in private white-owned homes for higher salaries, often in live-in positions.

[5] £82.68 at current exchange rate of 18.1:1 from www.xe.com on 22.09.2014

The nearest local town is around 30km away, and has a number of small shops, markets and a shopping arcade. In the market, stalls sell items such as *bheshu* (antelope skins worn today at traditional Zulu ceremonies), *capallana* (women's cloth skirts, similar to a sarong, worn by Mozambiquan women), *nyangana* and *cassava* (peanut plant leaves, cooked as spinach and yam: both staple food stuffs from mid-north Mozambique) and *uMuthi* (traditional medicines) sourced from various locations across Southern Africa.

The shopping arcade has several well-known high street shops familiar in low-income areas in South Africa that sell branded clothing, electrical goods and home furnishings. For example, Jet, Mr Price and Pep. The goods sold in these shops are mostly imported from China and the USA. Goods are typically purchased using short-term finance options such as *lay-by* (customers pay for the purchase in installments, but only receive the item once the full price is paid) and pay-day or longer term loans from African bank. There are also numerous fried chicken outlets, which are international franchised restaurants such as Kentucky Fried Chicken, Chicken Licken and Nando's. In the town people can also apply for and receive social care grant payments, attend court hearings and pay taxes and fines.

Visually, the town has poorly-maintained infrastructure. Municipal roads are potholed, buildings dilapidated, walls are covered in graffiti and litter is strewn across the pavements. Road signs are rusted and falling down and train tracks missing.

Although the Khaya'manzi community has been home to indigenous peoples since the Iron Age (Mountain 1990) ever since colonial rule in South Africa, ownership of land in the area and rights of governance have been a contentious issue. Over the intervening years, many black residents of Khaya'Manzi and the surrounding areas have been displaced and relocated through numerous eras of discriminatory policy.

In 1897 the remote and environmentally diverse area where Khaya'manzi is located was designated a National Game Reserve. As such, Black Africans whose homes were within the newly designated borders of the reserve were removed from historic ancestral land, with no alternative location provided (AFRA 2003). However, this kind of displacement of indigenous peoples from their lands so that it can become national nature reserve is a global phenomenon, and is not unique to South Africa (Dana Declaration on mobile peoples and conservation 2002; Chatty and Colchester 2002). What is unique is that people were forcibly displaced as wider policy of apartheid and that National Game Parks were seen as recreational areas only for white people.

In 1914 white, ex-army settlers known locally as the "Pioneers" were allocated land by the government, who developed sugar cane farming industry in the area and started a local farming settlement (Harrison 1989). Original Black African residence of the newly rezoned sugar farmland was disregarded and whilst no settlements were displaced from the area at this time, families lost their ability to use the area as grazing and for cultivation (AFRA 2002). As this is a highly productive agricultural zone, Black African residents are as such disadvantaged because they are denied access to the consequent financial benefits of agricultural participation in this area of Khaya'manzi (AFRA 2003).

Members of the Khaya'manzi community were again relocated during the Apartheid era, as discriminatory legislation meant that black people from the community were systematically displaced. Black African residents were forced to move from their homes in the Khaya'manzi area and relocated to designated Bantustans, and men were forced into becoming labour migrants to nearby cities or mines (AFRA 2002). Thus, black African residents of Khaya'manzi have long been subjected to situations of structural violence.

Khaya'manzi is now divided into 4 definitive village areas. Since 2008, it is evident here that efforts have been made to provide the previously disadvantaged, black African residents with permanent communal land, freehold plots in formalised settlements with built reconstruction and development program (RDP) houses and infrastructure such as free electricity, quality primary healthcare facilities, municipal water supply and solar powered hot water heaters (Office of the Premier 2006). Operation Sukuma Sakhe (OSS) has also assisted many with obtaining formal birth registration as South African citizens, national identification books and access to social security grants. Health services available across the villages include two government health clinics, a mobile clinic service, NGOs providing community health advice and women's rape care services. There is also access to vegetable gardening and building work provided by the community work program (CWP), which is a government funded job creation initiative. There are many small Zionist, Methodist and Catholic churches as well as education institutions: crèches, two government high schools and six government primary schools are located in Khaya'manzi.

Commercial volunteer placement providers operate in the more developed areas of Khaya'Manzi. These include high profile companies like African Impact and Reach Out Volunteers. Students and gap year travellers from the global north pay high prices to these companies for the experience of interaction with "orphans" in "slums" (African Impact 2013). Although these companies are quick to defend the positive impact of these tours, most income never reaches the community and children are labeled, stigmatized and commoditized (Weckesser 2011).

The different areas of Khaya'manzi are provided with resources and infrastructure by the government. A COGTA (Cooperation of Governance and Traditional Affairs) representative coordinates these allocations. COGTA representatives operate in place of the tribal chief, which, during the Apartheid era was a role highly integrated with the

implementation of the regime ideology. COGTA is a formal government department and COGTA representatives work with an elected committee of community members and are responsible for applications for government funding for the promotion of particularly building and service development within their area of jurisdiction. Consequently, areas with efficient and honest COGTA representatives are better developed than others. The COGTA system has, however, recently been criticised for its exclusion of women from community governance (Krugell et al 2010). Each village area of Khaya'manzi has its own COGTA representative and associated committee, who work in varying degrees of efficiency. As such, there is a strong visual disparity between areas (see Figures 2.4 to 2.7).

Village A is a formalised settlement of low cost, government funded RDP housing. This is in comparison with Village B, which is an informal settlement that mostly consists of houses made of tin with handmade rock walls alongside traditional *rondavels* (literally "round houses": circular dwellings that traditional buildings seen in homesteads in many areas of Africa). Village C comprises good quality housing, often rental properties, all with access to electricity and municipal water supplies, indoor bathrooms and septic tanks, whereas Village D is overcrowded farm workers accommodation, privately owned by sugar cane farms, and without electricity, clean water supply or sanitary toilets and sewage disposal. This is represented visually in figures 2.4 to 2.7.

Linguistic and ethnic contrasts are also evident between the different areas. Villages A, B and C comprise predominantly isiZulu-speaking families who originate from the Khaya'manzi area. Village D is, however, mostly home to first- or second-generation labour migrants and their families. Migrants originate from countries as diverse as Swaziland, Mozambique, Zimbabwe, Malawi and Lesotho. In Village D, languages spoken vary from Xhosa (Eastern Cape province of South Africa) Shangaan, Chope and

Xitsu (Mozambique), to Siswati (Swaziland origin). This provides some indication as to the diverse population of this particular village.

Figure 2.4:
RDP houses in Village A

Figure 2.5:
Handmade houses in Village B

Figure 2.6:
Good quality housing in Village C

Figure 2.7:
Poor quality farm workers accommodation in Village D

2.4 Conclusion

This chapter has presented an insight into South African history and the current setting and context of the country that is of relevance to this doctoral thesis. Details were also provided about the fieldwork location, Khaya'manzi, which is an area characterized by a history of structural violence, migration and enduring inequalities. Due to its location along international transport routes as well as policies of forced migration, it is a diverse community. There are several state and NGO initiatives working with the local community and there is access to communications and transport. The area has been exposed to modernity in increasing levels, since the change to democracy in 1998. Khaya'Manzi is, consequently, typical of the rest of South Africa, and many black Africans have exploited the opportunities associated with this increased modernity, which has created an emerging black African middle class. However, as a consequence of this, there is increased inequality within the black African demographic group, and this is manifested visually through living conditions, spatial areas and home type. This was displayed visually in figures 2.4-2.7

The next chapter will present the methods, research strategy, ethics, positionality and the experience I had whilst completing this practical research in KwaZulu-Natal province, South Africa.

Chapter 3: Methodology and Methods

3.1 Introduction

This chapter sets out the methodology and multiple methods used in the research design of this thesis, and the issues associated with undertaking this research in order to answer the following research questions:

1. What are women's intergenerational understandings of landscapes of fertility within the changing socio-economic context of rural South Africa?
2. How do patterns of migration intersect with women's landscapes of fertility?
3. To what extent does the HIV/AIDS pandemic in South Africa contribute to women's landscapes of fertility?

The first part of this chapter sets out the methodology for the study, which draws on anthropological approaches and African femininity perspectives, followed by the second section, which describes the procedural ethics processes undertaken. The third section is about negotiating access to the fieldwork site, sampling and obtaining access to South African Demographic and Health Survey Data (SADHS) data. The fourth section describes the data collection methods and the methods of analysis used so that rigour was ensured. The final section focuses on the positionality of the researcher informed by reflexivity.

The topic of this doctoral research is women's landscapes of fertility, within the context of the South African HIV pandemic and migration. This was explored using multiple methods within a sequential exploratory research design (Cresswell and Plano Clark 2011). Secondary, quantitative analysis of South African Demographic and Health Survey (SADHS) data was included in the study. This analysis was completed prior to

the qualitative fieldwork, which used the following research methods: non-participant observation, semi-structured and narrative interviews and a modified participatory mapping exercise. These qualitative and quantitative research methods were employed within a sequential exploratory research design informed by ethnographic fieldwork and African femininity perspectives.

Quantitative data from the SADHS conducted in 1998 and 2003 were analysed in order to provide a context to the study and develop the topic guides for use within qualitative interviews. This is a descriptive analysis, and was incorporated into the study in order to demonstrate changes in fertility preferences over a five-year period and the factors associated with this change. The changes identified in the quantitative analysis were then explored over a longer time frame, in terms of changes in fertility preferences, between generations through the ethnographic fieldwork.

Qualitative fieldwork consisted of ethnographic non-participant observation through which a snowball sample of respondents for semi-structured group and in-depth individual interviews was generated. Selected participants were later involved in a modified participatory mapping exercise within the fieldwork location. Appendix 1 provides a table of the demographic details of participants that were involved in interviews, the types of interview conducted and participation in the modified participatory mapping exercise.

3.2 Methodology

This doctoral research study has a sequential exploratory design that incorporated multiple methods. These included both quantitative statistical analysis and qualitative fieldwork. The quantitative analysis of SADHS was conducted from a positivist perspective whilst the methods employed in qualitative fieldwork were implemented

from an interpretative social constructivist perspective. Within the methodology, I draw on the principles of ethnographic fieldwork and the African femininity perspective in order to explore the research questions.

Scholars who subscribe to the positivist paradigm propose that the world has an ontological reality that is ever-present regardless of our level of understanding of it, which can be referred to as being mind-independent (Bryman 2008). Reality is present and exists outside of human form, even when there are no humans to experience that reality (Plowright 2011). This reality is objective, and positivists understand that there are no alternative interpretations of this single reality. The epistemological perspective employed by the positivist paradigm is concerned with objectivity: there is a subjective truth and knowledge of reality that you can extend knowledge of through the utilization of particular research methodologies, for example surveys, statistical data collection, experiments and clinical trials (Robson 2002).

In contrast, interpretative social constructivism is an appreciation that the ontological reality of the world is socially constructed: each human agent inhabits the same world, yet has one or more personal interpretations of it. Social constructivists understand that reality is made through relationships, psychological activities and shared understandings between humans. Consequently, this paradigm understands that reality is mind-dependent, which is a direct contrast to the mind-independent interpretation understanding of reality considered correct by positivist scholars (Plowright 2011). Consequently, it can be understood that there are multiple interpretations of the same world (Bryman 2008). The epistemological perspective taken by social constructivism is more complex than that argued by positivist scholars. Interpretative, social constructivist researchers aim to develop subjective understandings of relative perceptions of the world through conducting, for example, interviews or observation of human agents (Robson 2002).

Naturally then, there is tension between positivist and social constructivist scholars. Positivists criticise interpretative social constructivism as it is argued to be influenced by the researcher's understanding of participants' perspectives. Consequently, misunderstanding or misinterpretation of the world at both the level of the researcher and the participant can occur. As a result, interpretative research is often termed 'soft' research (Robson 2002). However, constructivists are also critical of the positivist paradigm and claim research of this kind to be non-inclusionary and narrow (Grix 2004). The appreciation and use of positivist and interpretative perspectives within a single study can, however, result in the generation of more reliable findings and triangulation of data (Greene 2007).

The quantitative analysis has been tested for rigour using tests of validity and reliability. Quantitative, statistical analysis provided an opportunity for secondary data analysis to illuminate the context and background of the complex topic of fertility preferences women's in South Africa on a national and local level. Within the qualitative methods, credibility was ensured through triangulation and persistent observation; transferability was ensured through the use of thick description through detailed accounts of field experiences and confirmability was established through triangulation and reflexivity throughout the research process (Lincoln and Guba 1985).

Ethnographic fieldwork

Ethnographic fieldwork was originally used in nineteenth century Western anthropology. During this period, it was a detailed, in-depth account of an 'other' community or culture (Stocking 1991). Consequently, traditional views of what constitutes ethnographic study conjure up images of intrepid, pioneering researchers venturing into unknown societies and cultures spending time and studying, observing

and learning socio-cultural customs and routines with an aim of gaining expert insight into this 'other' life. Generation of a successful ethnographic account was seen as a certain rite of passage into the upper echelons of anthropological academic hierarchy (Stocking 1991; 1995; Hammersly and Atkinson 2007). However, through influence over time from the Chicago school of sociology, cultural studies and human geography, ethnographic fieldwork is today acknowledged to be an inter-disciplinary strategy, through which detailed, in-depth knowledge can be generated about a certain social or cultural group of people or topic. This is usually achieved through the use of a combination of multiple qualitative methods (Robson 2002; Hammersly and Atkinson 2007; Bryman 2008).

In order to carry out a qualitative study using ethnographic fieldwork, in the community, Khaya'manzi, I used multiple practical research methods, which ensured the creation of the desired "rich tapestry" of information over sixteen months of fieldwork, between January 2012 and May 2013 (Cresswell 2006). I spent long periods of time observing as a non-participant observer in the daily life of participants before engaging in interviews with participants. This meant that I was able to gain a more detailed understanding of the socio-cultural context of the study location (Hammersly and Atkinson 2007).

Ethnographic fieldwork was used as a vehicle through which to generate the necessary in-depth and detailed findings. Consequently, insights into fertility preferences and related personal and socio-cultural circumstances and perspectives emerged. Ethnographic fieldwork thus provided the means through which the daily interactions and routines of research participants were observed, and further participants snowball-sampled and selected for participation in more formal, semi-structured or narrative interviews to hear and understand the lives and experiences of participants.

African Femininity Perspective

This doctoral research adopted the principles of the African femininity perspective. This perspective stems from the writings of postmodern feminist inquiry, which proposed that feminist principles can be adapted to ensure higher relevance to local socio-cultural contexts present within regions of study (Harding 1987; Webb 2000; Bryman 2008). Subsequently, this research methodology is located within the perspectives of a particular regional group of feminist scholars: those of the African femininity perspective.

A group of scholars, initially from Nigeria developed the African Femininity perspective as a critique of mainstream Western feminism. Scholars such as Amadiume (1987) Gaidzwana (1992) Meena (1992) Oyewumi (1997) and Tamale (2008) drew attention to the need for regional variations on Western feminist principles and epistemologies. This perspective acknowledged the importance of inclusionary research and challenged Western feminists for being blinkered in their quest for women's stories, consequently excluding the influence of men on women's lives. As such it is proposed that the full context and socio-cultural circumstances of the female research participants is not truly understood. Importantly, it is also claimed that Western feminist research has exacerbated the victimization of African women in depictions of them as *"victims of culture"* (Tamale 2008: 49).

The African femininity perspective is concerned with critical theory, and the understanding that the African woman is not a victim of her socio-cultural context. This perspective advocates that women are active in the production, reproduction, experience and manifestation of local socio-cultural norms and customs. Women demonstrate agency, and resilience as an expression of agency, in order to negotiate aspects of their socio-cultural context that can be perceived as constraining or prohibitive and in turn,

reproduce their own socio-cultural norms, more positive experiences and manifestations of the socio-cultural context (Tamale 2008). The African femininity perspective is also concerned with embracing change caused by the development of societies across Africa, and the acceptance of the inevitable change this creates in the role of women within their individual African socio-cultural contexts (Oyewumi 1997).

This doctoral research aims, through study of the stories of individual community members from Khaya'manzi, to raise awareness of the marginalization or structural violence experienced by the Khaya'manzi community within the local socio-cultural context, whilst still retaining the dignity of participants and taking care not to portray women as victims. This research instead relays the personal opinions and experiences of women's situations and socio-cultural contexts using a translation of their own words (Kolmar and Bartkowski 2000, Webb 2000). In this manner, the thesis draws attention to the agency, and resilience as an expression of this agency that is demonstrated by African women in their negotiation of structural constraints often posed by socio-cultural contexts, and other, related circumstances local to the fieldwork setting.

This study aimed to be as non-exclusionary as possible. In order to achieve this, participants led the interview and chose the topics of conversation. This meant that participants were able to discuss what they felt was of greatest importance to them within their lives and this provided a platform for a marginalized group of women to voice their own perspectives on fertility preferences and associated socio-cultural issues. Participants also decided the location of the interviews, which ensured that conversations took place in environments where they felt safe and comfortable. This had the result of creating a supportive atmosphere, where mutual knowledge creation could occur (Kvale 1996) and the uneven power relations that can sometimes be present in unequal interview situations (Robson 2002) minimized.

In order to adhere to the framework developed by the African scholars of femininity, discussion about men with significant relationships to participants was encouraged, and men were never excluded as a topic in conversation. Despite no individual interviews with men taking place, they were included in non-participant observation, and were part of four family group interviews. Men were also included in informal conversations during fieldwork. This is in direct opposition to traditional western feminist inquiry, which has been critiqued for being one-sided, and ignoring men, as such providing a one-sided perspective of women's lives (Tamale 2008).

Fieldwork conducted within the parameters of the African femininity perspective meant that within the thesis, knowledge and understanding could be extended about personal perspectives on fertility preferences and the associated socio-cultural context that is region-specific and culturally sensitive, inclusionary and non-discriminatory.

3.3 Ethics

In terms of procedural ethics, ethics permission was obtained from the Humanities and Social Sciences Research Ethics Committee (HSSREC) at the University of Warwick. This is the institution where the PhD is registered. This involved a rigorous ethical review of the proposed research. A second ethics permission was obtained through the University of KwaZulu-Natal (UKZN) Humanities and Social Sciences Research Ethics Committee (HSSREC) ethics committee, which subsequently provided the necessary, local, ethics approval. This local ethics approval was facilitated through the Africa Centre for Health and Population studies, which also acted as a local host institution. As part of this application process I completed an online training course and obtained a certificate in conducting ethical research. The confirmation letter of ethics approval from both these institutions are available to view in Appendix 2.

A further necessary element of the ethical permissions process was approval of the informed consent documents and information sheets that were used in the fieldwork process. All information and informed consent sheets for participants' involvement in this study were translated into isiZulu, which is the first language of the fieldwork location. These documents are presented in Appendix 3.

I obtained informed consent from all staff at all institutions where observation was conducted. These institutions were: two primary healthcare clinics, three crèches and the community project and associated school hostel offices and communal area. Posters providing information about my fieldwork were put up at institutions and community centres and hubs, prior to commencing fieldwork so that people using the centres and around the community might recognize why I was there. All interview participants were required to sign informed consent before participation in interviews. All informed consent for participants' involvement in this study was obtained in isiZulu language. Potential participants and their guardians where applicable, were offered information sheets and informed consent forms, usually at least two days before a scheduled interview. Consent forms were collected on a return visit. In that way, individuals had the opportunity to opt out of participation if necessary. However, no participants chose to opt out of participation in the research.

To further ensure anonymity and confidentiality of the study participants, all place names have been changed: Khaya'manzi is a pseudonym for the fieldwork location. All names of fieldwork participants are pseudonyms, and aside from identifying their country of origin, no identifying place names are mentioned in quotes from interviews or conversations with participants. Participants' details were anonymised at the time of transcription. All electronic data was stored securely on a password-protected computer, and backed up onto the university server, where it would automatically have

been encrypted. Any handwritten notes, and fieldwork diaries and journals were stored in a locked desk drawer at all times.

I did not receive any assistance with conducting interviews, translation or transcription of interview recordings. This meant that I could protect the identities of participants entirely, as I was the only person who was exposed to the content of the conversations.

There are further, ethical issues of practice that emerged from this research. In order to address these, before fieldwork commenced, I made connections with local clinics and non-governmental organisations (NGOs) for women's health support that operated in the area. I was subsequently able to make arrangements for referral of any participants that identified potential health problems, or those that were in need of psychological support. The actual need for these referrals was minimal. However, on two occasions I provided information to participants about HIV voluntary counseling and testing services (VCT) that were available at the local clinic. On a third occasion, I gave information to a participant about an NGO that operated locally, as she required help with care for her child who was suffering from a congenital disease.

An important ethical issue that arose was that of HIV disclosure. The topic of this thesis required in-depth and detailed discussion about HIV with participants, yet HIV sufferers are often stigmatised and discriminated against. Throughout this study, participants were never required or explicitly asked to reveal their HIV status, or the status of any member of their family. As a consequence, participant confidentiality was maintained at all times. This was particularly important within household and peer group interviews, as it is common for individuals to want to maintain their anonymity in terms of their HIV status.

3.4 Access and sampling of participants

Initial access to participants was negotiated during an exploratory visit to the fieldwork location, and access to the quantitative dataset was acquired through networking. During the fieldwork period, access to additional participants was negotiated through the development of relationships with community organisations and peer groups and spending time at community hubs.

Exploratory Visit

In order to establish that I was able to gain access to research participants in the fieldwork site, I made an exploratory visit to the location at the end of the first year of studying for this PhD, just prior to the upgrade review.

This exploratory visit took place between July and September 2011. The main purpose of the visit was to enquire as to whether the site was a feasible location for the research and that organisations in the area were in principle willing to support fieldwork. I also negotiated an affiliation with the Africa Centre for Population Studies in Somkhele, KwaZulu-Natal and started the process of negotiating access to the 1998 and 2003 SADHS datasets.

I established informal links with organizations in the area and identified community groups, NGOs and other charities that operated in the area that I could potentially contact on my return to undertake fieldwork. Whilst I had previously worked in the areas surrounding Khaya'manzi, after living for three years in Mozambique, and a year in the UK, I needed to better understand the changes that had taken place in the area, and increase my familiarity of the context of the fieldwork site as well as extend my understanding of local politics, laws, customs and socio-cultural community structure.

I was able to meet with the Children's Committee associated with a church-based community Project that was located in the Khaya'manzi area, and negotiated access to their associated community. A local activist, who was the director of the Project, was the Committee chair. In South Africa, each crèche has by law, to have a nominated children's committee. The aim of such committees is to ensure accountability within the crèche management, and to manage any funds that are earned by, or donated to the crèche. The Children's Committee of this particular church-based community Project worked to gain support and assistance for a network of eight crèches located in the Khaya'manzi area. Informal permission was granted during the exploratory visit by the Children's Committee for the fieldwork to be conducted using the Project as a base from which to access research participants. During the exploratory visit, I attended three meetings at the Project and with the Children's Committee in order to explain the scope of the potential research.

A further positive outcome of the exploratory visit to the fieldwork location was negotiation of an affiliation with the Africa Centre for Health and Population Studies for the duration of my PhD. The Africa Centre is a health surveillance research centre located in Somkhele. The Centre is funded by the Wellcome Trust and has international collaborators working alongside Centre staff conducting epidemiological, sociological and medical research and data collection within the local area. In addition, the Centre provides support to clinics and hospitals within the district. Professor Marie-Louise Newell, the director of the Centre agreed to assist me with ethical approval from UKZN, access to datasets and any necessary administrative or academic support. I also attended seminars at the Centre. During the exploratory visit, I also started the process of negotiating access to the 1998 and 2003 SADHS datasets.

Access to Quantitative Dataset

Originally the study intended using a mixed methods design in which, quantitative and qualitative data would be combined. However, due to logistical issues related to obtaining the SADHS data and use of different geographical areas for data collection, this design was altered to become a sequential exploratory study using multiple methods. On advice from the Africa Centre, I obtained a copy of the SADHS 1998 dataset online (www.measuredhs.com). Whilst a copy of the 1998 dataset was easily accessed online, the 2003 dataset appeared unknown to many sources. After extensive contact with government and non-government agencies, a chance encounter in a Durban doctor's surgery led me to a contact at the South African Medical Research Council (SAMRC) in Cape Town who had a copy of the 2003 dataset. After an exchange of emails, a failed attempt at use of the South African postal service, a blank CD and permission granted by the Minister of Health, I finally received the dataset and permission to use it in my research. As it turned out, research into the implementation of the SADHS identified that the area used for recruitment for participants was demographically different from the fieldwork location, and the quantitative data was less relevant than originally thought to the qualitative findings. As such, I had to deviate further from the initial research design, and the role of the DHS in my thesis was reduced to that of context using descriptive statistics rather than its original, central position.

Negotiating Access During Fieldwork and Sampling Participants

During the actual fieldwork period, which was between January 2012 and May 2013, I lived at home, which was close to but not located in the study area: Khaya'manzi. For reasons pertaining to safety and acceptability as well as convention, it would not have been appropriate for me to live within Khaya'manzi itself, whilst I was conducting

fieldwork. In terms of safety and what is acceptable within the context, I would have put myself at unnecessary risk, living, as a white woman in a black African area alone, for a prolonged period of time. It would also have been unacceptable and defied convention for me to do so, and would have caused problems in my personal family life. However, my home was around a twenty-minute drive from Khaya'manzi, so I was able to make daily field visits to the area during the fieldwork period.

Initially I negotiated access to participants through the church-based Community Project that I made informal arrangements and developed a relationship with during the exploratory visit. Through the connections I had made previously with this Project and its associated Children's Committee, I was able to access the first interview participants, and spent 25 days in the Project crèche as a non-participant observer.

Despite the valuable data and interesting conversations that I was able to have through the connections I made through this Project, I soon realised that Khaya'manzi was a much larger and more varied community that I had initially anticipated. Villages A and C were visible from the periphery of the area, the houses of their residents clearly visible from main roads, white tourist areas and shopping precincts. The residents of these villages are relatively well-off, Zulu speaking and mostly historically established residents of the area. However, Villages B and D are mostly hidden from view for different reasons. Village B consists of squatter accommodation and was formed progressively, on the last areas of available land at the back of Khaya'manzi within a densely forested area and thus not immediately visible until a good understanding of the geography of Khaya'manzi is established. More interestingly, Village D is made up of staff accommodation, which houses predominantly migrant workers, many of whom are undocumented. The houses (and residents) were purposefully hidden from view, as the farmers who owned the land and the accommodation in this village did not want the

quality of their proffered staff accommodation open to inspection, nor did they wish to be scrutinized about their employment of international migrants rather than local labour.

Once I had a better understanding of the diversity of Khaya'manzi, in order to increase access to participants from all village areas, I repositioned myself as a non-participant observer in community hubs, mainly outside the local general store and café. Here I was able to gain a better understanding of the full extent of the community and was able to meet people from different backgrounds. I used a snowball sampling strategy from this point on to access participants for group and individual interviews, and also to identify additional community hubs and organisations to position myself at in different sections of Khaya'manzi so that I would subsequently be able to gain access to participants from all different backgrounds.

A snowball sampling strategy was used to recruit participants as it was the most appropriate for use within a community setting that I was unfamiliar with. Through use of snowball sampling, I was able to recruit hard-to-reach participants for participation in interviews, and negotiate access into areas of the community that are not immediately visible to an outsider. By adopting this approach, I was able to access participants from all four villages in the Khaya'manzi community area. These four areas all had very different characteristics, and through accessing participants from each area, I was able to develop a rich and interesting dataset. Whilst I did not purposefully designate a desired sample number of participants from each village, I took care to ensure that I interviewed a relatively even spread of participants from across the village areas and spent equal amounts of time conducting observation at hubs across the four villages.

I made a pronounced effort to ensure that the sample reflected the diversity of women in terms of age as well as village of residence. As younger women were more timid, and less likely than older women to volunteer themselves for participation in interviews, I

made sure to actively search for willing younger participants. I also ensured that in family groups women of all generations were present where possible.

Consequently, the participants involved in this study were black African women from different generations and countries of origin. I did not purposefully set out to recruit male participants for individual interviews. However, I was careful not to exclude men from this study, in order to adhere to the principles of the African femininity perspective. If men were present whilst I was conducting a household or group interview, they were not turned away and were given the opportunity to join in the conversation should they wish to. Informal conversations with and observation of men also formed an integral part of the ethnographic fieldwork through non-participant observation.

3.5 Methods

This study incorporated multiple research methods: statistical analysis of SADHS, non-participant observation, semi-structured group and individual interviews, narrative individual interviews and modified participatory mapping.

Statistical analysis

Statistical analysis of the 1998 and 2003 SADHS datasets was conducted. Two types of variable of interest to this thesis were first identified: firstly, 10 variables referring to background demographic of interest to this study were identified. Secondly, 26 co-variables that could potentially influence the chosen dependent variable "ideal number of children" of respondents were identified. All variables selected for incorporation into the statistical analysis had to be present in both the 1998 and 2003 DHS datasets.

Before analysis could take place, all variables of interest were re-coded into categorical data. This is because the assumption of homogeneity of variances was violated by data type, so as a consequence, more robust tests could not be used. Data from each variable was then reduced. The 1998 and 2003 datasets were then merged together to form one large, whole dataset containing all responses from variables of interest from both years of survey.

Cross-tabulations were first generated using the 10 background demographic detail variables to provide statistical details referring to the survey sample and change in household and individual circumstances by race and/or province in South Africa between 1998 and 2003.

The "select if" function was then implemented on the previously selected variables of influence on "ideal number of children" to filter cases not from black/African ethnic group and to restrict cases to origin from KwaZulu-Natal province only. Cross tabs were then generated using the dependent variable "ideal number of children" and these previously selected variables of influence as independent variables to determine statistically significant association between co-variables and "ideal number of children" of respondent. Frequencies were generated, and statistical tests used were Cramer's V, Phi and Chi squared.

The statistical analysis provided an accurate, statistical interpretation of the change in fertility preferences of women over an important five-year period in recent, South African history. This quantitative representation provided a broad overall picture of change in fertility preferences on a national, and provincial level. However, typically of large-scale household and demographic surveys, any regional or local variation from these general trends was probably obscured. In addition, the incorporation of this type of data source could be problematic: the variable: "ideal number of children" refers to a

concept more complex than the simple answers generated in a numerical survey answer. In a quantitative survey situation, such as the DHS, women respond quickly to questions, giving answers that they are often socially-conditioned to produce. However, on more detailed investigation, when the complexity of the variable is explained, and what it pertains and refers to is discussed, their "ideal number of children" often changes from what their initial response indicated. This is what I found happened in this thesis, and whilst the quantitative analysis provided a starting point that was then expanded upon using the multiple, qualitative methods, it must be suggested here that a numeric response to such a complex question, although useful as an indication of trends cannot necessarily be relied upon as an accurate reflection of women's true, complex opinions on the matter.

Non-Participant Observation

Non-participant observation was used in this study, as it is a non-intrusive manner, through which knowledge about the studied community can be extended (Hammersly and Atkinson 2007; Li 2008). It also provided the means through which informal conversations with people could take place and as a medium through which to access participants to include in the research.

In total, I spent 78 days as a non-participant observer, positioned at different places within the community. I spent time observing at three crèches, the local store, a *shebeen* (unlicensed store selling alcohol), a *uWashe* (popular place for washing clothes) and other natural gathering locations. I also attended six church services of different denominations.

Table 3.1 Days spent conducting participant observation in community areas

Location	Days spent conducting non-participant observation
uWashe (washing area)	5
Water pipe	7
Community project	25
RDP crèche	2
Farming crèche	2
Granny's crèche	4
Auntie's crèche	4
RDP shopping centre	6
Farming residential area	4
Churches	3
Cash store and *shebeen*	16
Total	78

My position as a non-participant located at different points in the community provided an opportunity to quietly observe the everyday events, as well as informally chat with community members. I made detailed field notes and observed the different routine happenings. As note-taking can be intrusive to participants and hinder the process of observation (Robson 2002), I often walked away from the site to sit in my car or out of sight behind a tree, to write short notes, which I then extended when I returned home at the end of the day (Hammersley and Atkinson 2007).

Initially, I positioned myself as an observer at a crèche and associated Community Project managed by a church group. This is the Community Project that I made links with during the exploratory visit. This crèche was located in the commercial centre of Khaya'manzi. It is positioned opposite the main cash store, minibus taxi rank, market place and liquor store. Here, I mostly interacted with staff, parents of young children and adolescent girls (aged 16+) resident at the church's children's centre and located adjacent to the crèche. I also learned about the benevolent, BEE (Black Economic Empowerment) activities of local sugar cane farmers, and was able to observe the rhythm of the community hub across the road. However, after around 6 weeks of

observation here, I realized that this centre represented only a small section of the Khaya'manzi population, as small fees are charged for a child's place at the crèche, and the religious denomination is imposed on both the children and their parents. Consequently, many were unwilling or unable to become a part of the centre's associated community.

I gradually spent more time "hanging out" at the cash store, market place area and bottle store located across the road from the crèche. As this was the main shopping and drinking hub in the Khaya'manzi area, it was always busy. People came and went throughout the day and farm transport brought workers from the fields to the store after long days cutting or weeding sugar cane. Groups of friends would sit at tables positioned under the veranda, drinking beer or bottled cold drinks in the shade, eating *vetkoek* (savoury donuts) playing cards and talking. This area was busiest at 4pm, when dusk falls, and the working day was over. At the month end, on payday, the market place came alive. Grandmothers would sell second hand clothing from imported bails, traditional healers set up stands with roots, herbs and handmade potions and vendors peddle eggs and chickens. From conversations with people I met at this location, I became aware of the true extent of the Khaya'manzi area, and the existence of further, community areas, or villages that were less prominent than the central hub, and less affluent. I was later able to observe these further sections of the Khaya'manzi area, whilst located at different points in the smaller villages. In particular, I spent a great deal of time observing whilst seated on a tree stump at a *uWashe* (washing area) in a section of river behind a part of the community in village D and a second, informal crèche in an isolated area of Village A.

Through incorporation of non-participant observation in this study, I was able to observe the daily events and lives of people in Khaya'manzi without any confusion over my role within the groups where I was based. Importantly, this meant that I could fully

dedicate my time to the primary task of completing this research, rather than this being overshadowed by any secondary role, such as that of a volunteer. However, when I was observing at the crèches, I often helped out where needed, so whilst I did not have a formal volunteer role, I did sometimes assist with daily tasks within this environment. I found non-participant observation to be a non-intrusive manner through which I could observe, without interrupting or intruding too much into the lives of participants. I found that, particularly when I was based as a non-participant observer at the general store, after two or three days of "hanging out" there, people got used to me being there, and generally ignored me. This meant that I was able to make comprehensive notes and observe in detail the daily happenings of the area.

It could, however, be argued that as a non-participant observer, the researcher is always slightly removed from the situations being observed (Robson 2002). As the non-participant observer never experiences the observed situation, there may be a danger that some happenings, events, ritual or observed incident may be recorded incorrectly, as the researcher does not necessarily have a full understanding of the situation. During the fieldwork for this thesis, this may have happened on occasion. In order to ensure rigour on these occasions, when there was an incident or event that I felt I did not fully understand, I took care to request clarification from a research participant.

Semi-Structured Interviews and Narrative Interviews

Interviews, both semi-structured and narrative are a tool that can be useful in the construction of detailed knowledge about a topic (Robson 2002). Personal perspectives can be obtained through this method, something that other methods are often unable to achieve (Kvale 1996; Bryman 2008). In this thesis, the use of qualitative interviews with different generations of household members facilitated the construction of intergenerational perspectives, and understandings of temporal shifts in the experience

and perspectives on landscapes of fertility in rural South Africa. Additionally, and in order to ensure rigour, seven interviews were conducted with key informants and service providers or employers from the Khaya'manzi area. The demographic and professional information about these participants are presented in appendix 4.

In total, I interviewed a snowball sample of 31 women, and 7 men in groups with women (*Appendix 1*). The total qualitative sample is displayed in table 3.2, and the breakdown by interview type in table 3.3. I understand that participants were aged between 16 years and around 85 years[6]. However, not all older participants were certain of their exact age. Interviews were either semi-structured or narrative in style, and often, repeat interviews with the same participant were conducted. On numerous occasions, I began the interview process with a semi-structured interview with a participant, then returned for a longer, narrative interview, and again returned to interview the participant within a group of either their family or friends. The initial, semi-structured interviews provided a platform through which I could develop a rapport with the participant, get to know the basic details of their life and provide them with the opportunity to get used to me, and to feel comfortable talking to me. Later, within the interview situation the questioning style turned to narrative, which facilitated the telling of in-depth, detailed personal stories, which many participants found to be an enjoyable experience.

[6] In order to ensure the ethicality of interviews with the two sixteen year old girls, I obtained informed consent from themselves and their guardians. This is in accordance with advice issued to me by the UKZN HSSREC.

Table 3.2 Total qualitative interview participants

	Younger women <30 years		Older women 30+ years		Younger men <30 years		Older men 30+ years		Service providers	Totals
	International migrants	South Africans	International migrants	South Africans	International migrants	South Africans	International migrants	South Africans		
Individual interviews	4	5	7	5	0	0	0	0	5	**26**
Participation in peer group interviews	8	4	7	8	0	0	0	0	2	**29**
Participation in family group interviews	9	9	6	8	0	0	4	3	0	**39**
Participation in community mapping	0	2	2	0	0	0	0	0	0	**4**

Table 3.3 Interview-type conducted

Individual	Peer group	Family group	Repeat individual	Repeat peer group	Repeat family family group	Total
30	10	10	16	0	0	66

For example, on one occasion, it was the month end, around payday and I was sitting outside the cash store and noticed three older women in the shade to the side of the building. Each of them was selling something. One woman had a bail of second hand clothing, another fresh lettuce, spinach and butternut and the third seawater and traditional herbs. I approached them, greeted them and asked their names. We had a brief conversation about what they were selling, where they lived and who I was. I arranged to return the following morning to chat with them further, as it was late in the afternoon and they each had to return home to collect firewood and cook for their families. I returned the following day, and spent a period of around seven hours, talking with them and sitting beside them, learning a little bit about their lives and the area of Khaya'manzi where they live. I arranged individual interviews with each woman for the following week when they were less busy, and organized to meet each one at their respective homes. The conversation with the individual women was more focused on their own specific life. The contact I had had with them over the previous week meant that they felt comfortable speaking to me about their personal situations and more private aspects of their lives.

This procedure of gradually getting to know participants, and gaining their trust meant that I accessed a depth of detail about participants' lives, personal perspectives and circumstances, that perhaps a single more structured interview would not have gleaned (Holloway and Freshwater 2007).

Throughout the interview process, I noticed that younger women were often timid and overshadowed by willing older participants. I therefore made a concerted effort to ensure the sample was representative of age groups. Younger women also found the semi-structured style of interview more comfortable, as the topic guide acted as a prompt, when there was a lull in conversation, whereas middle-aged and particularly older women were usually comfortable from the outset relating the narratives of their lives.

It is important here to note the practical reasons why men were not recruited for participation in the individual interviews. This thesis concentrated on the perspectives of women on their fertility preferences and choices, as one component of their landscapes of fertility. From the perspective of fieldwork, within the isiZulu socio-cultural context, for myself as a white female researcher, working alone in the field, it would not have been appropriate or acceptable within the context for me to discuss sensitive topics related to fertility with men from Khaya'manzi. Men were, however, incorporated and included into group and family interviews when present, and I engaged in informal conversations with men whilst in the community engaging in non-participant observation.

Group Interviews

Group interviews provided a platform through which the perspectives and opinions of different generations of women (and seven men) could be juxtaposed and compared. Also, groups of female peer groups could be provided with the opportunity to discuss opinions and compare situations and stories.

Family groups, particularly those that included men provided an interesting insight into the power relations within the household, as many included individuals from all

generations. However, it was challenging to ensure that all voices were heard, as there was often a dominant husband, brother or grandmother who controlled the conversation. In these situations, after the family discussion, I made appointments with the individuals that appeared marginalized in the conversation to continue the discussion on a one-to-one basis. In this way all members of the family were provided with the opportunity to voice their opinions and I was able to access the views and in- depth experiences of all family or group members.

Interviews with Service Providers, Employers and Key Informants

In order to ensure rigour and confirm credibility in the study, a further 7 interviews were conducted with service providers (appendix 4). This provided a means through which I could confirm statements made by interview participants. The service providers interviewed in this way were clinic staff, farm foremen, local, white farmers and religious officers from two churches in Khaya'manzi. Interviews with service providers were generally shorter in length than those with regular participants, and more structured, as, particularly clinic staff were very busy and short of time.

These interviews were intrinsic to the research, as they provided an opportunity for me to explore a different version of the lived realities and experiences. For example, numerous participants recounted how they knew of undocumented migrants regularly refused access to clinics and/or refused treatment. However, two clinic nurses in separate service provider interviews refuted this claim. The security guard for the clinic who operated the gate and controlled access to the space also confirmed that this statement was incorrect. Or alternatively, the health personnel may have been telling me the policy but in reality acting differently. Without observation, this was not possible to verify. As such, it could be suggested that there were different perceived and

real experiences of different contexts. Triangulating data sources in this way is a means of improving the confirmability of qualitative data.

Modified Participatory Mapping

Initially, I planned to map demographic details of all interview participants, using Geographic Information Systems software (GIS). These details included region of origin and age group. This would have demonstrated the flows and patterns of international and national migration to the Khaya'manzi area. However, concerns were raised about how this would affect the anonymity of participants. In addition, the use of GIS in studies based in majority world countries has been critiqued not only for its exclusionary nature due to its reliance on specialist technology (Schroeder 1996) but of particular relevance to this thesis, its opposition to founding feminist principles in inclusionary research (Tamale 2008).

In order to include some form of mapping, yet ensure that this study was not exclusionary and adhered to the principles of the African femininity perspective, selected participants were invited to take part in a modified community mapping exercise. This took place towards the end of the fieldwork period.

Four women, two older and two younger were given a very basic, hand-drawn map of the Khaya'manzi area (Appendix 5) and walked with me individually around the community. They indicated on the map places that were important to them, and we discussed the significance of these identified places, as we walked. As we walked around the area, the women told me stories about their experiences of these places. The two older women took me on long routes around the area, and pointed out locations of interest such as designated religious ground, houses where children are cared for and vegetable gardens. The two younger women had much smaller areas of significance to

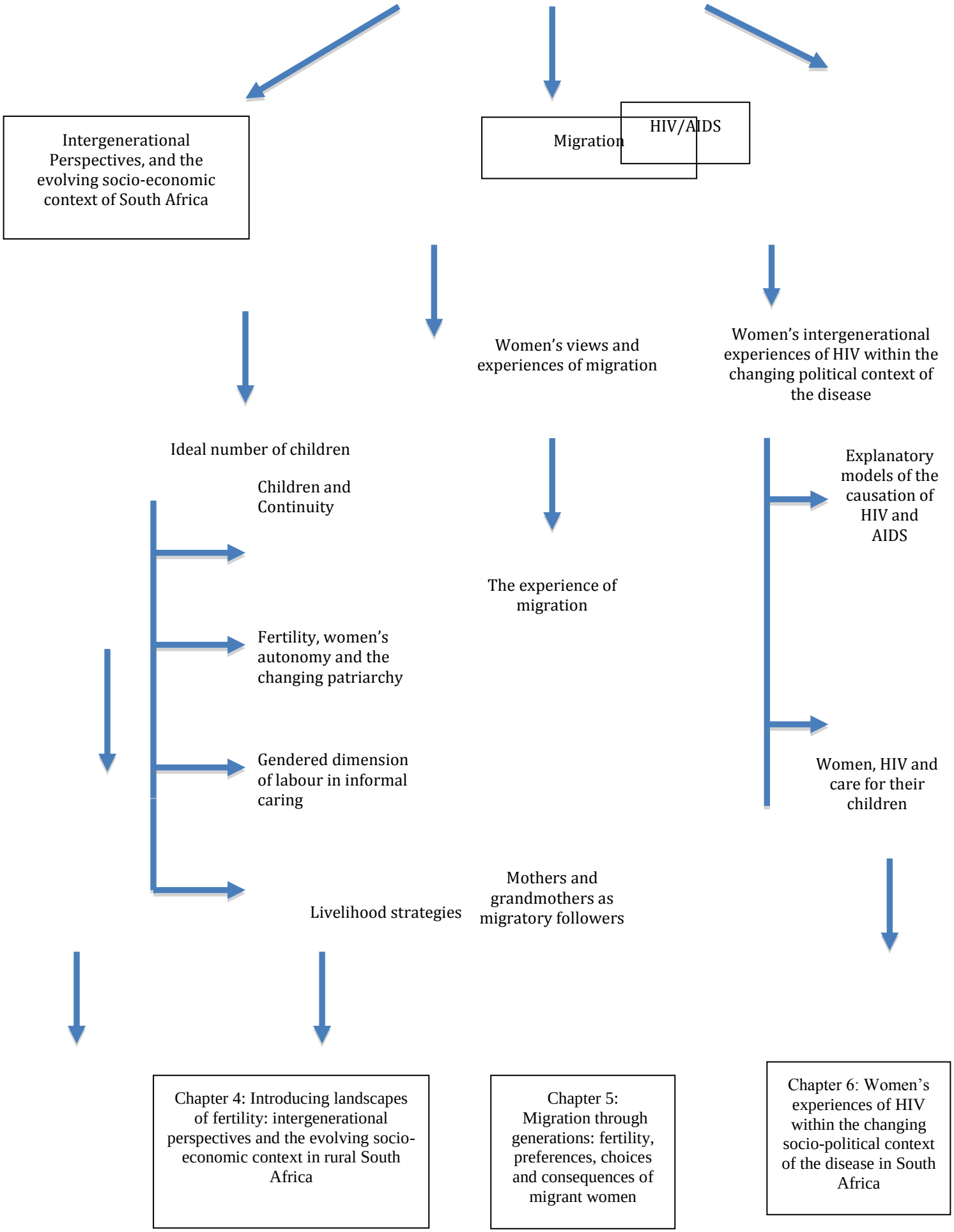
them within the community, and their places of interest mostly consisted of friends' houses, *shebeens* (informal, unlicensed drinking venues), bars, shops and taverns or informal movie houses where local television programs and movies are shown. This exercise enabled me to gain a deeper understanding of the significance of the places that these women had referred to within their interviews, and assisted me with my understanding of the different village areas within Khaya'manzi.

The qualitative research methods described here were all employed in everyday contexts within the field. For example, all interviews were conducted at community locations preferred by participants; non-participant observation was conducted at community locations and the modified community mapping exercise was relevant to spaces within the community that were known and used by the participants. This process can generate more valid, detailed and interesting data than that created in, for example, the contrived situation created in a highly structured interview (Cresswell 2003). Consequently, the multiple methods employed within the sequential exploratory research design of this doctoral research have facilitated the generation of detailed and rigorous findings to answer the research questions.

3.6 Analysis

The analysis of data for this thesis was undertaken in two stages. Firstly, quantitative analysis of the South African Demographic and Health Surveys from 1998 and 2003 was undertaken in SPSS, and second, qualitative, thematic analysis of qualitative fieldwork was carried out, supported by NVivo 10 software. The major themes that were identified in the analysis are presented in figure 3.1.

Figure 3.1: Diagram of Major Themes
Landscapes of fertility



Quantitative Analysis of SADHS, Using SPSS Software

Data from the 1998 and 2003 SADHS were analysed using SPSS software. The dependent variable "ideal number of children" was selected, and 29 independent variables concerning material household situations, relationship status and health status of participants were then identified. Statistical tests were performed in order to identify the statistical significance of each independent variable, either singly or in groups of multiple variables on the dependent variable. From then, I developed a picture of the factors that influence women's fertility preferences (ideal number of children). These descriptive findings were used to inform the topic guide for interviews and as a guideline to begin fieldwork.

Qualitative Analysis

Qualitative evidence for this thesis collected through fieldwork was in three forms:

1. Field notes from a daily diary kept during time spent in the field
2. Transcriptions of and notes from interviews with participants
3. Modified participatory mapping exercise, where places of importance were identified by participants and drawn onto basic maps of Khaya'manzi.

As with much ethnographic fieldwork, analysis of this evidence is an iterative and reflective process, with findings changing, adapting and extending as the process of analysis and writing up progresses (Brewer 2000).

The qualitative evidence collected through fieldwork was managed using NVivo 9 software and analysed thematically. Transcriptions and notes were initially analysed into lower order data and coded by creating parent and child nodes within the software to develop themes and also through allocating each participant a case node, and from

there developing relationship nodes between those within familial, work or friendship groups. Later, higher order categories of data were developed to identify themes from the findings.

This use of NVivo software in research may have helped to increase the rigour of the analysis process. This can be achieved by the role of NVivo software in allowing the researcher to easily conduct searches for themes within the dataset. This helps to ensure that all data is correctly categorised and none is left out of a thematic analysis. This is particularly important when dealing with large qualitative datasets, like the one for this thesis, as the sheer amount of data makes rigorous qualitative analysis difficult to achieve without help with this software (Welsh 2002). A diagram of major themes is presented in figure 3.1.

3.7 The Experience of Fieldwork: Reflexivity and Positionality

I conducted fieldwork for this project between January 2012 and May 2013.

I had originally planned to spread the fieldwork between two sites in KwaZulu-Natal province. This would have generated a comparative dataset. However, as fieldwork progressed it was decided, with guidance from my supervisors, to remain in the one study site as a greater depth of data was emerging after the initial fieldwork period of 2 months. The fieldwork site was located close to my home, and easily accessible. As a result the decision was made to exclude the second site from fieldwork, and instead spend the remainder of time allocated for fieldwork continuing research in Khaya'manzi.

Throughout the fieldwork period, I was relieved to find that people of all ages were interested in becoming involved in my research. Older women were, however, more

likely than younger women to put themselves forward and volunteer to be interviewed and become involved. Younger women were more timid, although once I had approached them and arranged to meet and discuss the project, they were willing and participated enthusiastically in the research. No participants decided to opt out of participation in the research.

It is now necessary to consider my position as a researcher, whilst working on this doctoral thesis and to be reflexive about the process of social research. This process is an intrinsic constituent of ethnographic enquiry (Hammersly and Atkinson 2007) and is central to the African femininity perspective (Tamale 2008).

I am a married, white female British researcher in my twenties, with two stepchildren. This project provided the opportunity for me to implement a detailed research project in an area that is predominantly black African, with high unemployment and low household income levels. As such, it is inevitable that the research was conducted from an outsider perspective. This could have created an imbalance of power relations between the participants and myself. It has been suggested that outsider researchers do not have enough in-depth knowledge about the studied community to develop a true representation of its situational reality (Thomas et al 2000; Robson 2002). However, I believe that my own experiences of working within the development sector across Southern Africa, and my proficiency at understanding and speaking isiZulu allowed me to develop a positive rapport with participants and become an accepted outsider to the community.

On numerous occasions, female participants either in interviews or informal conversations asked me about my home life, my family, my stepchildren or my husband. I found that being able to share stories of a family-oriented home-life with the women I was interviewing created a stronger rapport between us and made them feel

more comfortable about discussing their own situations. This was particularly the case with younger women. At various times, joking about our husbands, or boyfriends and telling anecdotes about children broke the ice at the beginning of an interview.

I never noticed when introducing myself as a British national, any prejudice or even comment from any of the research participants. Introducing myself as such, however, to migrant women in Khaya'manzi kindled a kind of solidarity between us, as they often understood that I was, a migrant too.

However, my being British did lead to an interesting debate one day with a white, English-speaking South African neighbour from my village. She is a woman who my partner and I know well, and she visited us at our house one evening just prior to the start of my fieldwork. We entered into a conversation about my fieldwork and PhD research, and she expressed strong opinions about the fieldwork area and farm workers living there. She even stated that as I was English, and not South African by birth, I wouldn't "be able to understand" the black people. She was clearly referring to the community's socio-cultural context rather than any language difficulties, as she knew I was able to speak isiZulu. She also suggested that I should not be upset if I did not find anything of interest because of the difficulty caused by the lack of understanding she was referring to that was, in her opinion typical of my nationality. I believe that this example demonstrates the lack of understanding typical of white, South African farm owners in the area.

Before I ventured out into the field, other, numerous white South African neighbours and friends warned me about the perils, dangers and evils of the rural, black farming communities. They provided examples of horror stories of crime and insecurity and warned me against taking unnecessary risks and venturing far from populated areas. I interpreted some comments as disapproval: in venturing beyond the gated, white

populated, farming village of my home, I was blurring the boundaries of my identity, and how I *should* behave as a white woman from the farming community. In doing fieldwork in black areas, I was venturing into the spaces of an "other", which is somewhere inappropriate to go.

For the most part, I, however, found black African community members friendly, giving, generous with both their time and meagre supplies (I was never without a cup of tea in my hand!). I felt comfortable walking alone in isolated areas, although always took care to carry a mobile phone and notify my partner where I was going and what time to expect me home. I sometimes felt a little bit harassed, when sitting at the *shebeen* (illegal store selling alcohol) at the end of the month, when it is a popular hangout for men to drink, whilst spending some of their wages. However, this is no different to feelings I had when working in a bar in the neighbouring white town, when it was close to closing time.

Throughout the whole fieldwork period, there was one single occasion when I felt ill at ease. In December 2012, I had finished interviews for the day, and stopped at the cash store to buy rice for supper at home. A policeman stopped me and suggested that I stay in the car, or go home and return later. I then noticed an ambulance and paediatric unit response car in the car park of the store, close to where I had parked. I asked the police officer what had happened, and he explained that a man had got drunk, and hit his stepchild on the head with a *tholemba* (machete). The child was bleeding to death but paramedics were doing their best to stabilise him. I reversed the car, and was about to head towards home, when the man in question was roughly pushed towards a police van. I recognised that he was the boyfriend of a woman I had spent many hours talking to outside the store and at the crèche opposite. The child had attended the crèche. However, the next morning, news came through that the child would recover, the man was in custody and everyone carried on with their daily lives.

Any other challenges I encountered were caused by the manner and attitude of participants towards each other and myself.

I was seen as a young married white woman with resources: a large four-by-four car, clothes, a husband and a home. I noticed in some situations, perhaps because of my personal circumstances some women were envious of me, and others perceived that I was very affluent and should help them financially. In particular, a number of the younger women who participated in this study, either through the process of observation or the pre-arranged interviews, presented their children to me as hungry, inadequately dressed and unwell as a tactic to solicit my sympathy, and hopefully a financial donation. In most cases, this was found later to be untrue, as very few participants in this study went without food. However, their actions were caused by a reaction from them to my physical characteristics, and a process known as *"tata ma chance"* which is a Zulu term that comes from the English catch phrase, adopted by the national lotto draw, and aptly used to described individuals who are willing to "take a chance" to obtain money from another by a slightly comical, but still calculated and underhand means. Participants who *"tata ma chance"* could have become quite an obstacle to achieving quality interviews with younger women, as they were not honest about their personal circumstances. However, I managed to overcome the situation through use of humour, often by teasing the women in question in front of neighbours and other people, and laughing with them. In this way, I let the participants know that I understood that they were trying to use the situation to their, mostly financial benefit. Once this understanding was gained and barriers were broken down in our relationship, I was able to discuss interesting topics with the women, and they happily voiced their opinions on many issues and situations.

Whilst communication with participants did not prove to be problematic, particularly male participants within family group interviews often made incorrect assumptions about my level of proficiency at speaking and understanding isiZulu. When convening group interviews, I spoke very little, only occasionally offering prompts to ensure that the conversation was steered towards topics of relevance to the thesis. Men often entered the interview situation late, after we had started, and so missed my introduction, which would have been the only opportunity for participants to hear my proficiency at speaking and understanding the language. As such, men would often assume that I could not understand what they were saying, and would direct more polite comments and discussion towards me, mostly spoken in isiZulu, but interspersed with words of English, in an attempt to ensure I could understand them. However, they would then add comments, or additions to their statements, or even instructions to the women in the room directed at the other family members, under the assumption that I would not be able to understand their rudeness. In these situations, I was never able to correct the situation, and demonstrate my level of understanding, and as such this provided an insight into the underlying and hidden power relations within the household, particularly between men and women, that I would otherwise have been excluded from witnessing.

A final challenge that I encountered is related to the very high prevalence of HIV in Khaya'manzi. Whilst there are no accurate statistics for infection, as Khaya'manzi is located outside of population surveillance areas, the high levels of national and international labour migration to the area, combined with the poverty levels mean that HIV is highly prevalent (AFRA 2002). It is estimated that infection levels within women of reproductive age (14 to 35 years) could be as high as 75% (AFRA 2003). Despite the gradual shift of HIV to be considered a chronic condition, because of the now widespread availability of improved antiretroviral therapy (ART), which prolongs life and improves the health of infected individuals, death rates are still high in

populations with high levels of infection (Bor et al 2013). During the fieldwork period, six research participants died from HIV-related causes. As well as the practical challenges this posed in terms of returning to interview these participants, the experience of the deaths of these people I knew was a difficult situation to come to terms with.

I was invited to attend four of the funerals, and was able to go to two of them. One was a small occasion, as the deceased had few relatives still alive. The ceremony was a Christian service held at a local church and led by a pastor. The second service, was a traditional, rural South African funeral, held at a Zion bush church. The ceremony was focused on the return of the body of the deceased to the ancestors for guidance, care and peaceful passage into what is believed to be the next stage of existence. I can honestly say that this service was the most emotionally draining funeral I have ever attended. This experience did, however, enable me to understand the religious context of the studied community far better than I had previously.

3.8 Conclusion

In this chapter I have presented the main issues and observations surrounding methodology, methods and analysis, ethics, reflexivity positionality and the experience of carrying out fieldwork for this PhD in KwaZulu-Natal, South Africa. The chapter presented the sequential exploratory methodology used in this thesis, and discussed the multiple methods employed in order to answer the three research questions:

1. What are women's intergenerational understandings of landscapes of fertility within the changing socio-economic context of rural South Africa?
2. How do patterns of migration intersect with women's landscapes of fertility?

3. To what extent does the HIV/AIDS pandemic in South Africa contribute to women's landscapes of fertility?

The next three chapters, Chapters 4-6, present the findings of this research study, each of which answer one of the above three research questions. Chapter Four is divided into parts A and B. Part A presents the descriptive statistics that illustrate women's change in fertility preferences between 1998 and 2003, and factors that may be associated with this change. Part B of the chapter offers insights gained from qualitative fieldwork into the inter-generational differences in women's fertility preferences, and the potential reasons for these differences over a lengthened timeframe in an exploration of the perspectives of women from different generations.

Chapter 4: Introducing landscapes of fertility: intergenerational perspectives and the evolving socio-economic context in rural South Africa

4.1 Introduction

This chapter addresses the first research question: What are women's intergenerational understandings of landscapes of fertility within the changing socio-economic context of rural South Africa?

This chapter is divided into parts A and B and incorporates both quantitative and qualitative data in order to answer the research question.

Part A presents a quantitative analysis of data from the 1998 and 2003 South African Demographic and Health Surveys (SADHS). This analysis consists of descriptive statistics that provide an overview of change in black African women's ideal number of children between 1998 and 2003, and later explores the factors that may have influenced this change during this short but important period of time[7]. The analysis provides a statistical point of reference for further analysis and findings presented later in the thesis.

Part B builds on the quantitative findings by exploring intergenerational changes in women's perspectives relevant to landscapes of fertility over a longer period of time. This is achieved through presentation of analysis of qualitative data drawn from interviews with women from different generations. The analysis also draws on field-notes made during the research period. Thus, part B presents the views of women about

[7] Social and political change linked to the transition to democracy is discussed in more detail in chapter 2, which explores the setting of this PhD research.

their fertility and associated preferences, choices and consequences, located within the changing socio-economic context of rural South Africa.

The first section of part B is about children and continuity, the second addresses the changing influence of the patriarchal societal structure on women's autonomy and how this has influenced fertility preferences, choices and consequences. The third section is about how external influences are changing the gendered division of care within the household and the fourth and final theme focuses on children's role in women's use of livelihood strategies for survival.

Part A: South African Demographic and Health Survey (SADHS) Analysis

4.2: Statistical Associations with Changes in Black African Women's Fertility Preferences Between 1998 and 2003

Analysis of selected variables from the South African Demographic and Health Surveys (SADHS) from 1998 and 2003 was undertaken using SPSS software, in order to provide an insight into factors that may have influenced any reported change in black African women's fertility preferences between 1998 and 2003.

As explained in Chapter 2, the period between 1998 and 2003 was a phase of rapid socio-political change in South Africa. During this period of time, the country also experienced rapidly increasing levels of modernity stimulated by the first democratic elections that took place in 1994 (Schwartz 2009). Politically, the year 1998 was towards the end of the term of office of Nelson Mandela who was the first democratically elected president of the country, and 2003 was a year during the Mbeki presidency. In the period of time between these data collection points, numerous policies were implemented in the country in order to improve the previously

discriminatory conditions that were imposed during Apartheid (1948-1994). There was a particular concentration on the implementation of policies that focused on equal opportunities for all people and also affirmative action for previously disadvantaged demographic groups. As a result of the extreme structural violence experienced by black African people during Apartheid, the majority of these policies focused on improving conditions and opportunities for this demographic group. Of particular relevance to landscapes of fertility, increased access to socio-economic opportunities of this kind can have a knock on effect on women's fertility preferences, and result in a reduction of the average desired number of children of affected women (Bongaarts 1990; Schwartz 2009).

The analysis of SADHS data presented in this section demonstrates that black African women in South Africa experienced a statistically significant change in their fertility preferences between 1998 and 2003. Part A further demonstrates that there are numerous variables that may be associated with these changes. The dependent variable of interest was women's "ideal number of children" which indicates fertility preferences, and explanatory variables of interest were split into categories that provided relevant indicators of respondent's circumstances. These were: respondent's education, details of respondent's place of residence and perspectives on family planning. In addition to the main analysis presented here, Appendix 6 provides tables that illustrate the characteristics of the sample.

Changes in Ideal Number of Children

Changes in fertility preferences of women, from a perceived ideal larger to smaller family size can be associated with increased levels of opportunity and development (Bongaarts 1990; Schwartz 2009). It is understood that changes in fertility preferences of this kind have a knock-on-effect on birth rates and as such can be a direct indicator of

future, reduced population numbers. Reduced population numbers are indicative of the development index of a population group or country, as well as modernity (Moultrie et al 2008).

Table 4.1 demonstrates changes between 1998 and 2003 in the ideal number of children of women from different racial groups in South Africa.

Black African women experienced a statistically significant change in their ideal number of children, albeit with a low effect size ($p<0.05$, Cramer's $v = .106$). The proportion of women from this demographic group who desired 1-2 children increased from 43.8% in 1998 to 51.1% in 2003. Proportions of women who desired 3-5 and 6+ children declined. As such it can be inferred that the overall, desired ideal number of children of black African women decreased during the period. Other racial groups in the country also experienced a statistically significant change in ideal number of children during this period.

Table 4.1: Ideal number of children nationally, by ethnicity, demonstrating year of survey

Ethnicity	**Ideal number of children**	**Year of survey**		**Statistics**
		1998	**2003**	
Black/African	None 1-2 3-5 6+ Total	235 (2.6%) 3938 (43.8%) 4161 (46.3%) 659 (7.3%) 8993 (100%)	195 (3.8%) 2640 (51.1%) 2169 (41.9%) 167 (3.2%) 5171 (100%)	*χ^2 =160.103* *df =3* *p<0.05* *Cramer's V = .106*
Coloured	None 1-2 3-5 6+ Total	47 (3.1%) 906 (59.1%) 495 (32.3%) 85 (5.5%) 1533 (100%)	48 (5.2%) 565 (61.1%) 280 (30.3%) 31 (3.4%) 924 (100%)	*χ^2 =13.738* *df =3* *p<0.05* *Cramer's V =.075*
White	None 1-2 3-5 6+ Total	40 (5.3%) 462 (61.2%) 234 (31.0%) 19 (2.5%) 755 (100%)	29 (10.9%) 169 (63.2%) 68 (25.5%) 1 (0.4%) 267 (100%)	*χ^2 =15.846* *df =3* *p<0.05* *Cramer's V = .125*
Asian/Indian	None 1-2 3-5 6+ Total	10 (2.5%) 249 (63.4%) 118 (30.0%) 16 (4.1%) 393 (100%)	14 (2.4%) 428 (72.3%) 140 (23.6%) 10 (1.7%) 592 (100%)	*χ^2 =11.521* *df =3* *p<0.05* *Cramer's V =.108*

Table 4.2 demonstrates black African women's change in ideal number of children within KwaZulu-Natal, which is the province of interest for this thesis. The situation within the province is atypical of the national trends identified in Table 4.1. Whilst black African women experienced the same statistically significant change in ideal number of children, no other demographic group experienced a statistically significant change in ideal number of children.

Table 4.2: Ideal number of children for participants from KwaZulu-Natal by ethnicity demonstrating difference between years of survey

Ethnicity	**Ideal number of children**	**Year of Survey**		**Statistics**
		1998	**2003**	
Black/African	None 1-2 3-5 6+ Total	32 (2.3%) 538 (39.3%) 677 (49.4%) 123 (9%) 1370 (100%)	20 (3%) 399 (60.5%) 230 (35%) 10 (1.5%) 659 (100%)	χ^2 *square = 103.220; df = 3; p<0.05; Cramer's V = .226*
Coloured	None 1-2 3-5 6+ Total	0 (0%) 16 (55.2%) 10 (34.5%) 3 (10.3%) 29 (100%)	0 (0%) 20 (69%) 9 (31%) 0 (0%) 29 (100%)	χ^2 *square = 3.497; df = 2; p = NS*
White	None 1-2 3-5 6+ Total	5 (5%) 57 (63%) 28 (31%) 1 (1%) 91 (100%)	3 (10%) 20 (67%) 7 (23%) 0 (0%) 30 (100%)	χ^2 *square = 1.511; df = 2; p = NS*
Asian/Indian	None 1-2 3-5 6+ Total	8 (2.5%) 218 (68%) 88 (27%) 8 (2.5%) 322 (100%)	12 (2.4%) 367 (74.4%) 110 (22.3%) 4 (0.9%) 493	χ^2 *Square = 6.956; df = 3; p = NS*

Different categories of variables from the SADHS may be associated with this statistically significant change in fertility preferences experienced by black African women between 1998 and 2003. These categories are: respondent's education, details of respondent's place of residence and respondent's perspectives on family planning. Within these categories, there are specific variables that may be associated with change in the dependent variable and as such may be used to suggest potential reasons for this

change in the ideal number of children of black African women between 1998 and 2003.

Educational Background of Participants

After the Apartheid era ended in 1994, the newly elected government introduced policies and programmes that provided opportunities for historically disadvantaged people (May 2010). Such initiatives created increased levels of modernity through improved access to opportunities and services. Between 1998 and 2003, the effects and influence of such policies and programmes would have been felt intensely within the black African demographic group. Some programmes focused directly on gender specific education for black African girls and women. These programmes aimed to increase school attendance and retention of girls, as well as women's literacy. School classes such as life orientation (LO) were, and still are used to promote empowerment and development, and improved literacy through community-based classes was promoted in order to improve family health (May 2000).

Table 4.3 indicates, on a national level, the highest educational level of participants from different racial groups and how this changed between 1998 and 2003. Black African women experienced a statistically significant change in educational attainment during this period ($p<0.05$; Cramer's V =.116), with a higher proportion of participants accessing education at all levels. Racial groups other than white also experienced similar statistically significant changes, and improvements in access to education.

Table 4.3 highest educational level of participants nationally, by ethnicity demonstrating difference between year of survey

Ethnicity	Highest education level	Year of Survey		Statistics
		1998	**2003**	
Black/African	No education Primary Secondary Higher Total	710 (7.9%) 2606 (29.0%) 5168 (57.5%) 509 (5.7%) 8993 (100%)	282 (5.4%) 1059 (20.2%) 3538 (67.6%) 354 (6.8%) 5233 (100%)	χ^2 =190.169 df =3 p<0.05 Cramer's V = .116
Coloured	No education Primary Secondary Higher Total	87 (5.7%) 471 (30.7%) 909 (59.3%) 66 (4.3%) 1533 (100%)	49 (5.3%) 201 (21.5%) 642 (68.8%) 414 (4.4%) 933 (100%)	χ^2 =26.487 df =3 p<0.05 Cramer's V = .104
White	No education Primary Secondary Higher Total	3 (0.4%) 5 (0.7%) 505 (66.9%) 242 (32.1%) 755 (100%)	0 (0%) 1 (0.4%) 193 (70.4%) 80 (29.2%) 274 (100%)	χ^2 =2.291 df =3 p=NS
Asian/Indian	No education Primary Secondary Higher Total	5 (1.3%) 39 (9.9%) 310 (78.9%) 39 (9.9%) 393 (100%)	6 (1.1%) 26 (4.4%) 442 (74.2%) 122 (20.5%) 596 (100%)	χ^2 =28.169 df =3 p<0.05 Cramer's V = .169

Schwartz argues that improving educational levels of a group of women is associated with increasing modernity of a country or region and will, consequently influence their fertility preferences, and result in a reduction in their ideal number of children (Schwartz 2009). Table 4.4 demonstrates that improved education levels of women may be associated with change in ideal number of children of black African women between 1998 and 2003.

Table 4.4: Association between black/African respondents' highest educational attainment and change in ideal number of children between 1998 and 2003 nationally

Highest educational attainment	Ideal number of children	Year of survey		Statistics
		1998	**2003**	
None	0 children 1-2 children 3-5 children 6+ children Total	.7% 17.8% 54.8% 26.7% 100%	0% 31.3% 62.5% 6.3% 100%	*χ^2 =4.056 df =3; p= NS*
Primary	0 children 1-2 children 3-5 children 6+ children Total	3.9% 28.4% 52.1% 15.5% 100%	2.9% 49% 45.2% 2.9% 100%	*χ^2 =21.771; df=3; p<0.05; Cramer's V= .212*
Secondary	0 children 1-2 children 3-5 children 6+ children Total	1.9% 47.5% 47.3% 3.2% 100%	3.4% 63.5% 31.9% 1.2% 100%	*χ^2 =39.870; df-3; p<0.05; Cramer's V= .177*
Higher	0 children 1-2 children 3-5 children 6+ children Total	1.2% 47.6% 47.6% 3.7% 100%	0% 65% 35% 0% 100%	*χ^2 =4.462; df=3; p=NS*

However the association between improved education level and change in ideal number of children does vary within the analysis. For women who had achieved both primary and secondary school education levels, this factor had a statistically significant association with change in their ideal number of children ($p<0.05$, and Cramer's v = .212 and .177 respectively). The effect size of the influence was larger for women who had achieved primary school level than for those who achieved secondary school level.

However, for women who attained higher education levels, this was no statistically significant association of this variable on change in their ideal number of children. It could be suggested that these already high achieving women would probably not have been a target group for education programmes during this period (May 2000). In addition, for women without any school-based educational attainment, this factor did

not have a statistically significant association on any change in ideal number of children between 1998 and 2003. This may be because they were not exposed to any school-based education programmes, and as such did not experience any increased access to opportunity in this manner, which can be, in turn associated with reduction in ideal family size.

Women's literacy levels are also reported to have an influence on women's fertility preferences (Schwartz 2009). Table 4.5 demonstrates the association of this explanatory variable with change in black African women's ideal number of children between 1998 and 2003.

Table 4.5: Association between black African respondents' literacy level and change in ideal number of children between 1998 and 2003, nationally.

Literacy	**Ideal number of children**	**Year of survey**		**Statistics**
		1998	**2003**	
Reads easily	0 children 1-2 children 3-5 children 6+ children Total	2.3% 43% 48.5% 6.2% 100%	0% 65.4% 34.6% 0% 100%	*χ^2 =6.135; df=3; p=NS*
Reads with difficulty	0 children 1-2 children 3-5 children 6+ children Total	3.3% 24.8% 54.5% 17.4% 100%	3.2% 61.3% 34% 1.5% 100%	*χ^2 =94.733; df=3; p<0.05; Cramer's V=.366*
Cannot read	0 children 1-2 children 3-5 children 6+ children Total	1.8% 15.9% 54% 28.3% 100%	0% 50% 0% 50% 100%	*χ^2 =2.818; df=3; p=NS*

Women who read easily are the only group that experienced this factor as having a statistically significant association with change in ideal number of children, however, this finding had a medium effect size ($p<0.05$, Cramer's $V = .366$).

Details of Respondent's Place of Residence

One particular state funded initiative aimed at improving the physical living conditions of previously disadvantaged people in South Africa was the Reconstruction and Development Programme (RDP), described in Chapter 2. This programme was implemented by the first democratically elected government and led by Nelson Mandela. This programme is still in existence today. The RDP involved direct improvements to physical living conditions of particularly black African residents of the country (Blumenfield 1997). Key improvements to living facilities implemented within the RDP were improved access to water, and improved toilet facilities for black African communities (May 2000).

In terms of association with black African women's change in ideal number of children between 1998 and 2003, all women regardless of change in access to electricity or change in toilet facility experienced a statistically significant change in their ideal number of children. Table 4.6 demonstrates the association between electricity supply and change in ideal number of children.

Table 4.6: Association between 'respondent has electricity' and change in ideal number of children between 1998 and 2003

Has electricity	**Ideal number of children**	**Year of survey**		**Statistics**
		1998	**2003**	
No	0 children 1-2 children 3-5 children 6+ children Total	2.3% 26.1% 57.1% 14.6% 100%	2.7% 63.9% 31.6% 1.9% 100%	*χ^2 =115.347; df=3; p<0.05; Cramer's V=.383*
Yes	0 children 1-2 children 3-5 children 6+ children Total	2.4% 47.8% 44.4% 5.4% 100%	3.3% 58.2% 37.2% 1.3% 100%	*χ^2 =21.109; df=3; p<0.05; Cramer's V=.131*

Women who did not have electricity experienced a stronger effect size in terms of the association of the variable on change in ideal number of children ($p<0.05$; Cramer's V = .383).

Table 4.7 demonstrates the statistically significant relationship between black African women's access to type of toilet facility and change in ideal number of children between 1998 and 2003.

Table 4.7: Condensed table demonstrating association between respondents' type of toilet facility and change in ideal number of children between 1998 and 2003

Type of toilet	**Ideal number of children**	**Year of survey**		**Statistics**
		1998	**2003**	
Pit latrine	0 children 1-2 children 3-5 children 6+ children Total	2.2% 37.9% 51.3% 8.6% 100%	0% 88.5% 11.5% 0% 100%	*χ^2 =26.504; df=3; p<0.05; Cramer's V= .215*
No facility	0 children 1-2 children 3-5 children 6+ children Total	2.1% 19.3% 56.2% 22.3% 100%	9.4% 71.9% 18.8% 0% 100%	*χ^2 =49.947; df=3; p<0.05; Cramer's V=.434*

Women who had no toilet facility and those who had a pit latrine experienced a statistically significant change in ideal number of children, with those without access to a toilet facility experiencing the largest effect size ($p<0.05$; Cramer's V = .434).

As such, it can be inferred that black African women who had access to the lowest level of household facilities experienced the greatest change in their ideal number of children between 1998 and 2003. As previously suggested, this change can be associated with increased levels of development, and in terms of policy and intervention, the most disadvantaged people in the country were those who were targeted for improvement and empowerment in different ways. As such, the findings pertaining to this topic can be understood to correlate with other literature that demonstrates how women from the most disadvantaged situations experienced the highest level of change in their ideal number of children between 1998 and 2003.

Women's access to and knowledge of family planning is widely associated with a reduction in ideal family size (Schwartz 2009). Under the first Ministry of Health, led by Nkosazana Dlamini-Zuma, between 1994 and 1999, the availability of primary healthcare services to previously disadvantaged communities was improved. These services included access to contraception and family planning, as well as sexual and reproductive health services (May 2000). Table 4.8 demonstrates black African women's knowledge of contraception, indicating a statistically significant association between 1998 and 2003 and increasing numbers of women with knowledge of contraception. This reflects the state implemented, improved access, to primary healthcare services for black African women during this period.

Table 4.8: Women's knowledge of contraception, by year of survey, restricted to black African demographic group

Knowledge of contraception	**Year of Survey**			
	1998		**2003**	
	%	**N**	**%**	**N**
Yes	92.3	1265	95.2	631
No	7.7	105	4.8	32
N	**100**	**1370**	**100**	**663**

$\chi^2 = 5.725$; df =1; $p < 0.05$; Cramer's V = .053

In terms of association with change in black African women's ideal number of children between 1998 and 2003, Table 4.9 indicates that when women are aware of contraception, this has a statistically significant association with change in ideal number of children ($p<0.05$; Cramer's V=.234).

Table 4.9: Association between respondents' knowledge of contraception and change in ideal number of children between 1998 and 2003

Knowledge of contraception	**Ideal number of children**	**Year of survey**		**Statistics**
		1998	**2003**	
No	0 children 1-2 children 3-5 children 6+ children Total	8.6% 41.9% 40% 9.5% 100%	15.6% 46.9% 34.4% 3.1% 100%	*χ^2 =2.786; df=3. P=NS*
Yes	0 children 1-2 children 3-5 children 6+ children Total	1.8% 39.1% 50.2% 8.9% 100%	2.4% 61.2% 34.9% 1.4% 100%	*χ^2 =103.786; df-3, p<o.o5; Cramer's V=.234*

Part A Conclusion

This basic analysis of the South African demographic and health surveys from 1998 and 2003 has revealed that black African women's ideal number of children changed during the period. Variables that may be associated with this change in fertility preferences were respondents' education, various details of place of residence and knowledge of family planning. These variables are factors within the landscapes of fertility that relate to the wider socio-political context of the time, they can change over time and are often subject to influence by changing political agenda. They may be associated with the increasing levels of modernity that black African women in South Africa would have been exposed to after the fall of the discriminatory Apartheid regime.

In Part B, qualitative data will be drawn upon in order to gain a deeper understanding of the social context behind the changing fertility preferences identified in Part A. This

will be explored within the landscapes of fertility of black African women in South Africa. Qualitative data was obtained through extended interviews with individual participants and households. Women of all generations were interviewed in order to gain insights into the changing perspectives on their landscapes of fertility over a longer, multi-generational timeframe. Field notes and informal conversations provide further in-depth insights into women's intergenerational perspectives on their fertility preferences, choices and consequences and extend understandings of landscapes of fertility.

Part B: Landscapes of fertility, Perspectives of Women from Different Generations

4.3 Women's Intergenerational Perspectives on Their Fertility Choices and Preferences Within Their Landscapes of Fertility.

Part B extends the quantitative findings presented in part A, through discussion of women's intergenerational perspectives on fertility preferences and choices, relevant to their landscapes of fertility. The findings presented in part B explore the topic over a longer time frame and uses analysis of qualitative fieldwork data obtained through interviews with women of different generations, field notes and informal conversations. Various themes were identified from analysis that were relevant to the landscapes of fertility: children and continuity; the changing influence of the patriarchal societal structure on women's autonomy and how this has influenced fertility choices; how external influences are changing the gendered division of care within the household and finally, children's role in women's use of livelihood strategies for survival. These themes are explored here in part B.

4.4 Children and Continuity

Children are central to women's landscapes of fertility. Participants frequently discussed the role children had within the context of the family, and the significance of these roles in relation to the concept of time. Children were described as being important members of most families, in terms of their role in the continuation of family lines, the proliferation of cultural norms and activities, and the importance of retaining links with family ancestors. As a consequence of the importance placed on the role of children within the family and community, when women were unable to have children, they experienced feelings of failure and insecurity.

Children's Role in the Continuation of Family Lines

Participants identified the family as important within landscapes of fertility. This is because, within the black African socio-cultural context, the continuation of family lines is important to promote familial expansion and proliferation into the future. This ensures the wealth, health and strength of family members. This can in turn facilitate access to positions of power within structures of governance in the community. Importantly, the continuation of family lines ensures the accumulation of material wealth through generations (Ngwane 1997).

One participant, Zodwa is South African and has five living children, seven grandchildren and is about fifty years old. She explained why the continuation of her family is important to her:

"If you are a man, you have to have [as many] children, as you can, often through having many wives. Let me give you an example of our president: when a man has children, it means his family will continue forever…He then has the respect of everyone in the community for a man it is very important to have the respect… So, as a wife, it is important for me to help my man get this respect by giving him many children, if I can't

he will probably take another wife…When he has respect, he can get a good position in the community, and of course this will give him money and wealth, which I get too, and then it means that the children, grandchildren and all the other later children get it as well" (Zodwa, 50, South Africa).

Thus, a woman's ability to have children and the choices women make about their fertility are significant and of great importance to the black African socio-cultural context. Children are intrinsic to the continuation of family lines, and the associated benefits this can provide to the family, both present and future generations.

Older women who held the socio-cultural norms associated with black African society in high regard, tended to have a strong sense of responsibility towards their role as a mother, and the subsequent role of their children in the continuation of their family. As one participant identified:

"My children are the future, so, they are important. Women have children, not men. It is the woman's role to make sure that there are children to continue our family" (Mbali, 54, South African).

Often, participants did not see themselves as individually important, but in having children they perceived that they could guarantee the continuation of their family line and ensure that the family would continue into subsequent generations. Siba is an older woman, who explained that she came from a traditional Zulu family. She believed:

"Women themselves, they mean nothing, it is the women having children that are important. When you are a mother, then you are important, because you have the children who can make your family live forever" (Siba, 85, South Africa).

Once a woman has produced children and grandchildren for the purpose of continuing the family line, then, and only then has she fulfilled her role and provided for her family. As one older woman, Thombi explained:

"It is true in my culture that a woman only gets respected once she is a mother, she gets more respect when she is a grandmother. It is because everyone then knows that the woman has done her life's work" (Thombi, 64, South Africa).

Therefore it can be understood that being fertile is of great importance for women, and whilst an individual woman is not important, her achievement of her reproductive role and her family are. Thus, women's fertility preferences and choices may have an influence on the future prosperity and survival of her family.

Continuation of Culture

Cultural values were seen by some to shape landscapes of fertility. Participants discussed how black African culture and values that have been present in communities for generations can be perpetuated and safeguarded through the expansion of families by having many children. Black African culture was described as complex and varied between individual circumstances, but was simultaneously a shared experience and heritage that bound women together in a form of solidarity. Some, older participants understood that processes like modernity are a threat to the survival of the black African socio-cultural context and values and the social structure of communities like Khaya'manzi. As such, it is understood that having children and the consequent expansion of families is important in order to assist with the proliferation of these socio-cultural norms and customs that can be perceived as under threat.

Rebecca explained, using her own memories of growing up, how she perceived that customs intrinsic to her community were now under threat because of modern influences:

"It used to be very different here in Africa. We used to live our lives as we were told, we had different jobs to do at different times in our lives. It was important for us to get married, to have children and to look after our husbands. We girls were all friends in the villages…children were polite and also knew their jobs, the men, they were important, and we had safe communities….Now it is not like that. Women have no idea about their work, they go off and get fancy clothes, loans, jobs, cars and do not look after their men and do their jobs. Children do not know their culture, and have no manners. The organisation of our communities is not working anymore and they are not safe…This television, everyone wants to be like this person or that or have this or that, we Zulu people, we do not need this" (Rebecca, 50, Mozambique).

Other older women suggested that it was important for women to have children within family situations so that these socio-cultural norms could be resurrected and protected in the face of the perceived threat posed by the encroaching modernisation of society. As one participant expressed:

"If every woman has many children, that they bring up in the family, the community…and they in turn have many children too, then we can teach them all the values we need to make sure our culture does not die" (Nancy, 60, Mozambique).

Another participant, Zodwa, expressed the view that the African household is founded on respect for other family members and its existence is pivotal for the development of safe, prosperous communities. In order to ensure that the household continued to exist in this form, she felt that it was important that women lived in family circumstances and

teach their children about their socio-cultural norms, their heritage and associated behaviour:

"Look at these places where there is no family, no fathers, just mothers who abandon their children. It is rough, you need to have children brought up in a proper family so they learn properly how to be people. Having children in a family are important for the future" (Zodwa, 50, South African).

Thus, for women to whom the conventional socio-cultural norms of black African society are important, having children, particularly within a family, is important for the continuation of the black African culture. In this way, these women understand that culture shapes their landscapes of fertility.

Continuation of Links with the Past

The past is also relevant to landscapes of fertility, particularly, past generations of the family. Participants explained how children have a role to play in terms of retaining important links with past generations of families. In Southern Africa, it is mostly understood that once a family member dies, they enter the afterlife, or spirit world, where they are reunited with other, deceased, members of their family (Ngwane 1997). These are the ancestors *(okhokho)*. Ancestors are responsible for the spiritual and day-to-day guidance of their relatives still resident on earth in the living world. The ancestors are also responsible for the fate or providence of the family. If there is a large family left in the living world, this means that there are many people with the capacity to remember the deceased, and placate them through participation in rituals such as sacrifice and guidance ceremonies. This enables the ancestors to prosper, and in turn, they facilitate the success of their family in the living world. It is believed that the more children a family have, the more likely it is that once the older generations of the family

have passed away, they will be remembered by people remaining on earth and their souls will be afforded eternal life in the spirit world (Ngwane 1997). Thus, having a large number of children is understood to guarantee the future prosperity of the family. Thuli explained:

"I think in English you would call it remembering. I need children so that when I am the ancestor, I am remembered by someone still on earth, that is what keeps me alive, it is people's memories, and the only memories that you will stay in is those of your kin – your children. Without their remembering, I would die here on earth and be gone forever" (Thuli, 62, South African).

Thuli was an older participant, who discussed her own responsibility towards her ancestors, and her ancestors' role in the future prosperity of her family. Thuli invited me to her home so that I could observe her conduct a ceremony where she received guidance from her ancestors about a specific matter that was concerning her. Here is an extract from my field diary on that day.

"I sat in the lounge of the house watching the TV in the corner showing Isidingo (popular South African soap), whilst Thuli left the room to prepare herself). About 15 minutes later, she returned to the lounge, dressed in the church uniform of a white tunic, with her head covered in white cloth. She was wearing the badge of Zion, pinned onto her the tunic and had bare feet. The badge of Zion is the star of David, worn as a silver badge. The badge is an indication that the wearer is a member of the Zionist church community. In South Africa, dedicated members of Zionist church communities are meant to wear the badge at all times, usually outer garments. We walked out, and into the garden area of the plot towards the beehive hut. The beehive hut was small, with an extremely small door that I had to crouch down to enter by. We entered the hut with difficulty – I had to help Thuli, as her knees were sore. Thuli had a bunch of

"Mphephu" (curry bush herb), which she placed on a pile of bricks in the centre of the hut and set light to. The room was filled with a strong, acrid smoke.

Thuli began to chant in Zulu "siyakhuluma," which means, "we talk" over and over again, followed by the names of whom I assumed to be her ancestors. She started swaying, and began to have a conversation with the fire.

After around 15 minutes, when all the mphephu had burned away, she sat up and ushered me out of the hut. She explained that she would clean properly in the hut later so as not to contaminate the sacred space for next time the guidance ceremony is performed by either her or another member of her family" (Extract from field diary, Thuli's house, 30.11.2012).

In retaining dialogue of this kind with familial ancestors, it is understood that they are included in the daily activity of the family members on earth. The more family members who are on earth to communicate with the ancestors, the more guidance the family receives, and therefore the more likely the family is to prosper. As one participant explained:

"The ancestors like it when they are talked to a lot. All of my family talk to the ancestors, because they can guide us. Things happen in the living world that it is difficult for humans to understand, but ancestors are all-seeing, and they can explain things that are beyond our understanding to help us see better ourselves…If there is a lot of people talking to the ancestors in a family, then as a family we can understand better, because we have the eye of the ancestors, who can see further than us" (Willow, 60, South African).

Therefore, links between current and past generations of the family are seen as important within landscapes of fertility. Having children to safeguard the continuity of the family is seen as an important action that is needed to ensure the success of the family in the future, as determined by the ancestors.

Inability to Have Children

It has been demonstrated that the black African socio-cultural context tends to place a high level of importance on women's fertility and ability to have children. As well as inspiring, in some cases, a sense of responsibility towards their reproductive role, this can also mean that some women can feel pressured by these socio-cultural norms into having children. As a consequence, if women are unable to conceive, they often feel as if they have failed to fulfil their societally designated role (Ncgobo 1990). In addition, an inability to conceive can result in an interruption in the continuity created by children in the woman's life, both in terms of ensuring the future of her family, and of retaining links with the past. These negative feelings can be exacerbated, by the attitude of other family and community members, as customarily, in black African, and other communities globally, if a couple cannot conceive, the blame for this failure to conform to societal norms and designated roles is placed on the woman (Ncgobo 1990).

Some participants indicated that they felt under pressure from members of their family to conceive. In particular, it was suggested that mothers-in-law were particularly aggressive in their attitudes towards their daughters-in-law in terms of demanding children, offering advice and remedies to speed up conception, and were often insulting towards their daughters-in-law. As one participant expressed:

"My mother-in-law used to talk, talking all the time, no break, asking when am I having children, are we even bothering to try, why are we not taking her wishes into our

concern…. She was ugly to me, screaming, shouting, at me, saying I am useless to my husband and father-in-law…Telling my husband to take another wife to give her the children" (Doma, 24, South African).

Participants who found it difficult to conceive, or for whom conception took longer than perhaps is understood to be usual, and, those who were unable to conceive at all described how they felt as though they had failed to fulfil the role that society had designated them. One participant in particular indicated that it took over five years after her marriage for her to have her first child. She explained:

"It felt as if everyone was being horrid to me behind my back, there were whispers about me all the time… My husband's family were so ugly to me, they made me feel like I was useless and had failed. I wasn't a mother, so I wasn't worth anything….Without having children, they weren't allowing me to be a part of their family" (Patience, 30, South Africa).

For women who were unable to conceive at all, it is clear that this situation caused a lifetime of concern and worry. One participant, Vanessa, was in her seventies. She has never had children. Vanessa believes that once she dies, all links to her family's past history, achievements and story will be severed:

"Without children, I cannot make it that my family will prosper in the future. I won't have anyone on the ground, my family name will die. There will be none of us left, because we will not have a future, and when you do not have a future you lose your relationship with your past. That means we are dead." (Vanessa, 70, Mozambique).

As Vanessa is the last generation of her family, and has never had children, she believes that she failed to facilitate her family's continuation and expansion into later generations. This made her feel guilty and concerned:

"It is all my fault, there is nothing left of my family for the future… I worry for my own health in the living world, and when I become an ancestor, I won't be an ancestor as there is no one left in the living world for me to be an ancestor of" (Vanessa, 70, Mozambique).

This preservation of the relationship between deceased ancestors and living family members was a concern central to the lives of many older women I spoke to. There was a widespread feeling of anxiety that these older women will one day soon, themselves be the *okhokho* (ancestors), and if they do not have children, grandchildren and extended families on earth to carry on the family into future generations, then they themselves will be forgotten, and will become lost.

"You get lost in the other world when you die and you have no children. Your children are your anchor to the earth, and what is the earth but what you know, so what happens when you don't have children? You lose your way. That means that your family is lost, you are lost" (Mina, 64, South African).

Section Conclusion

Children are intrinsic to landscapes of fertility. However, the importance placed upon the role of children in terms of family lines, the proliferation of cultural norms and retaining links with ancestors varied between women of different generations. Older women clearly held the socio-cultural norms of black African society in high regard and felt comfortable within the parameters of the socio-cultural context. Some felt concern

that increased progress was jeopardizing the customary culture of their society and changing their way of life. This can happen when majority world countries are exposed to modernity particularly through exposure to dominant Western media and commercial products (Giddens 1991). Older women identified that being fertile and having children was important for the continuity of family and community in Khaya'manzi, within their local socio-cultural context. Their fertility preferences and choice to have children was seen as intrinsic to their landscapes of fertility, as children are important for providing familial and cultural stability in the future, as well as retaining links with past ancestors. Thus, women's landscapes of fertility were influenced by understandings of the importance of continuity of family.

However, situations that are enabling or positive to some can be structurally constraining to others (Gesler 1992). The socio-cultural context of black African society that was enabling to older women could arguably be described as a constraining to younger women within households and families. This was particularly evident in terms of the attitudes of older women towards younger women in their household who had difficulty with or delay in conception. The described perspectives of older women that were formed by these socio-cultural norms meant that they often blamed the younger women in their household for problems with fertility (Ardabily 2011). Therefore, within this socio-cultural context, should a woman be unable to conceive, she may suffer acute negativity and sadness about her experiences of fertility. However, women from different generations associate these feelings with different situations. For younger women, an inability to conceive can be associated with loneliness and familial disproval, but for older women having no children is associated with a concern over future wellbeing and an inability to fulfill her role within society and her household or family. As a consequence of the importance placed on the role of children within the family and community, when women were unable to have children,

they experienced feelings of failure and insecurity. Women from different generations, therefore, inhabit different landscapes of fertility.

4.5 Fertility, Women's Autonomy and the Changing Patriarchy

Historically, the community of Khaya'manzi would have been a patriarchal stronghold, dominated by an ideology that was typically male centred, in terms of property ownership, inheritance and decision making in the public and private spheres. A patriarchy is understood to be a "system of domination of man over woman, which transcends...economic systems, eras, regions and class" (Coetzee 2001:300). The views and needs of women in a patriarchal society are secondary to those of men and this was the case in the multi-origin society of Khaya'manzi as well as Zulu societies in South Africa and most societies globally (Ngwane 1997).

In South Africa, as in many societies during the twentieth and twenty-first century, there has been a decline in patriarchy with the rise of modernity and associated ideologies and opportunities such as feminism and equal opportunities legislation. The ability to make fertility choices with the assistance of readily available contraceptive tablets or injections has taken place alongside this. This has been influenced by women's access to education and employment as well as legislation and has heavily impacted on black Africans in South Africa (Schwartz 2009).

However, black African household structure although customarily patriarchal, has, during and since the Apartheid era also been shaped by the socio-economic context and structural violence created by labour migration and unemployment in South Africa. Husbands and fathers often work away from home in cities, only returning to their home communities for short periods of time. This means that many women have to raise their

children without the constant support of a partner living at home. Women often have children outside of formal marriage, owing to factors such as prohibitively high cost of *lobola* (bride price paid by the husband's family to that of his wife on marriage, similar to a dowry). Consequently, economic progress, modernisation and the structural violence and influence of Apartheid on the family and household have caused the influence of the patriarchal structure to decline. Thus women have experienced increased autonomy and opportunities for independence (Coetzee 2001).

The changing influence of the patriarchal societal structure is important within landscapes of fertility. Both women in relationships, and those who were single discussed their fertility choices and preferences in terms of their increasing personal autonomy and their own experiences of this changing influence of the patriarchal structure of their community. Women in relationships indicated that they had experienced a change in their position, and societally designated roles, which provided them with more personal agency, meaning that they felt more able to make more choices about their fertility. Single mothers explained their perspectives on having children, and situations of increasing independence. Women also discussed their experiences of improved access to primary healthcare facilities and their consequent ability to control their fertility and others explained how women's increased freedom of choice has led to gender stereotyping of children and a preference for female children in the community.

The Changing Position of Women in Relationships

Women from younger generations, who were in secure relationships experienced changes in their societally designated position, particularly in terms of the expectations other family members had of their role within the household.

Previously, a married black African woman would be expected to stay within the homestead to care for her children, her husband and their home. The husband would have little interaction with the children, and would not be expected to participate in any aspects of care for them. As male children reached the age of adolescence, they would, however, be expected to spend more time with their father. The father would teach them the societal norms and knowledge needed to progress through the socio-cultural rites of passage and ceremonies that customarily began at adolescence. Female children would have little contact with their father. The women in the house would be expected to provide for the children and grandchildren (Ngwane 1997). This situation, however, appears to be changing. During fieldwork, women from younger generations, who were in relationships described how they had increased autonomy and the ability to make their own fertility choices. They explained how they felt more able to act on their own fertility preferences, rather than having to conform to these norms previously adopted and enforced by the patriarchal structure of the community.

Married participants, in their late teens, twenties and thirties expressed the view that whilst they felt proud of their heritage, and enjoyed their own role within their community, they still wished to retain, to some degree, the independence they experienced as single women. This was described as being particularly in terms of access to opportunities to further their education or career. However, simultaneously, these women indicated that they were also unwilling to sacrifice their need or wish to have children. As one participant explained:

"I am married under traditional law and I live with my husband's family. I appreciate the support that I get and the childhood that my children will have because we live here, but I am a modern woman and I know that I can have an education, a job and still have all these things. It is the modern way of our society now, things have changed!" (Patience, 30, South African).

Women in situations of this kind explained how they managed to negotiate mutually acceptable arrangements with their partners, with regards to childcare and economically active roles within their relationships. As Pumeli explained:

"I work, my man looks after the children, we live with his family, and when I get home and on the weekends I help to cook and look after the other children" (Pumeli, 19, South Africa).

This division of labour enabled women like Pumeli to achieve the balance between their socio-cultural participation and exploiting the other opportunities available to them. These are situations that previously would have been restricted, and not allowed within the community. This is due to the expectations that men had of the role and duties of their wives within the household that was part of the patriarchal structure of the community. As Davey explained:

"Thirty years ago, I wouldn't be able to work, study, have two children and live with my mother-in-law. It just wouldn't have been accepted. My mother-in-law, my husband and the rest of his family would have wanted me just to stay home, look after the children and cook… Now, this culture it is changing, we married women have more opportunities, we can have children, work, study, see our friends, it is not like before" (Davey, 27, South Africa).

Other participants, who were in stable relationships, chose, with the support of their partners to control their fertility, in order to choose when they had children. Pumeli was one example:

"I didn't want to have children until we had more money saved, and my boyfriend didn't mind. We decided that we would work, I would go on the contraceptive pill, and then in around five years, we could go back home and live with his family and there it would be better for us to have children… We would have the support of the families…. My boyfriend doesn't mind, he also has a job, and wants to save before we have children. I am studying at UNISA[8] and I work in the evenings, so we don't have time to bring up a child properly at the moment" (Pumeli, 19, South Africa).

This meant that Pumeli and her boyfriend could prioritise other areas of their lives, and they would only have children at a time appropriate for them.

Pretty was another participant who felt this way. She was in her twenties, and also in a relationship. Although she wanted to have children, she preferred to wait before starting a family. She worked in the town close to Khaya'manzi, and had been recommended for a promotion. Pretty understood that her situation was fortunate as her husband supported her in her fertility preferences, and understood that she wanted to control her fertility in order to concentrate on furthering her career. As such, she felt that she was able to retain her independence and autonomy financially, which provided her with decision-making leverage in her relationship. However, she was still in a position to have children when she wanted to, and provide them with a supportive upbringing within the community, and her extended family. This was clearly important to her:

"I am lucky, because my husband lets me do this, he knows that I want children, so he will get them one day, and his mom can be a grandma. For now he is happy to let me work because I earn good money and it makes me happy… It makes me feel brave to ask

[8] University of South Africa, which offers distance-learning opportunities.

for what I want because I know I have my savings and my income that can help me if he throws me out or something" (Pretty, 28, South African).

Earning money has long been understood to be a method of control over women in households, by men in societies globally (Coetzee 2001). Other participants explained that similarly to Pretty, they enjoyed working, and on occasion being the main breadwinner in their household or at least one of the wage earners. Being in this position meant that they felt they had a greater degree of autonomy within their relationships, and, as such, were more confident in voicing their opinions to their husbands and extended families, particularly with regards to their fertility preferences, and choices about their children's upbringing.

Holli had experienced this situation. She married when she was young, and had a child before she was twenty years old. She passed her matriculation examination (school leavers certificate) and found a job as a housekeeper at a hotel. She gradually progressed up the career ladder, and now has a high position in the same hotel in the housekeeping division. She explained:

"Before, when I was still at school, I took time out to have a baby, I got married to the baby's father. I was a shy, little quiet thing, my husband wanted to have a baby, so I had one, my husband wanted to do this, so we did it… I think I got more and more confidence… When I got matric I was proud, but still quiet, when I got my first pay, I brought it home and I said to him, this is my money, half goes to the house, and half goes to my bank. From that day, I have been brave, now I am telling him, no, I don't want another baby right now, wait a year…He knows that I have money now, and I have confidence. My money has helped me become the independent woman, and thank God for that, now I don't have to have babies every year!!!" (Holli, 32, South African).

Younger women have experienced changes in their position within society and many are now able to access additional opportunities for studying or working whilst simultaneously being a mother. Thus, it can be suggested, that for many younger women, landscapes of fertility are changing because of the influence of the changing patriarchy and other societal changes as well as the consequent, changes in the socio-cultural and socio-economic context of their lives.

Independence and Single Motherhood

Customarily, children born to single mothers in black African communities would have been absorbed within the extended family, and exposed to care and disciplinary measures provided by older family members as well as their parent (Ngwane 1997). The exposure of black African communities to processes such as migration, modernity and the impact of infectious disease have resulted in more and more children being brought up outside of their extended family homes and outside the influence of the household, and has perhaps resulted in the increase in occurrence of the Western concept of single motherhood.

Single mothers from Khaya'manzi discussed how their own personal situations and experiences of caring for a child alone reinforced, for them, their feelings of independence and autonomy. In particular, these women described the intersection of these feelings and situations with the modern black African context, and how, they believed, it was important for a modern, young, black African woman to have and experience having a baby of their own *(Umntwana wami).*

"Every women should have a baby of their own, so that they can say "my baby", so they can care for "my baby" and be with "my baby". My baby is mine, just mine, nobody else. It is the modern way" (Beauty, 25, South Africa).

Precious explained, how as a single mother, she felt independent and free, as she was able to make decisions without the intervention of a husband or boyfriend.

"It is important for a modern black woman to be independent and to be able to make her own decisions. As a single mom, I am free to do that. I am free from the power of a man. I am free to live my own life" (Precious, 22, Mozambique).

Thus, the act of caring for a child alone can be seen as reinforcing a woman's self-belief in her own independent status. This is closely associated with the strong sense of responsibility that particularly single mothers expressed towards their children.

"My child is important to me, I care for her by myself, and I care for her properly, very well. I don't let anyone else look after her, well only people I trust, if it is really necessary, but if anything happens I feel responsible…"My baby belongs to me, not to my boyfriend. My boyfriend is not the father of my baby, so he doesn't have any right to tell me what to do about my baby" (Menenhle, 18, South African).

Women who discussed this perspective mostly tended to describe themselves as modern *(ngiyamuhla)*, and often spoke derogatively about the conventional Zulu household and community structure. As one participant explained:

"I think it is stupid, you have all these lazy old men, they just sit around, but we have to be all quiet and shy and a good Zulu maiden and do what they want, they don't want us to have our own lives. It is not right. I hate it. That is why I am modern" (Nomzamo, 16, Swaziland).

Some younger women expressed concern with regards to the style of upbringing their children would have, should they enter into a relationship with a man from the area and thus become part of a household and live with other family members. In particular, participants indicated that this would mean they would be controlled, rather than independent and autonomous, and this would have negative repercussions on their child's upbringing. Sn'tile explained her perspective on this situation and why she had chosen to bring her child up as a single mother, without the support of the baby's father:

"If [I] was married, then [I] would be controlled. This way [as a single mother] [I] can be in control of [my]self and [my] son. He is [my] baby" (Sn'tile, 21, South Africa).

One participant explained that for her, the influence of a mother-in-law would be particularly damaging both for her own independence and wellbeing and that of her child.

"That is the one thing that for me, would be a big problem. I cannot live in the house of a mother-in-law. I will be controlled, I will not be able to do things my way, I will hate her…. Mothers-in-law always hate their son's wives in our culture" (Nobuhle, 16, South Africa).

However, some older participants suggested that this concept of women having "my baby", and single mothers bringing their children up without the support of a household can create a situation of disadvantage, particularly for the child. Zodwa suggested that whilst modern, younger women were positive about their experiences of independent single motherhood, this could impact negatively on the children involved. She explained how single younger women took on too much individual responsibility for

their children and from her perspective and experience as an older woman saw this as a selfish, possessive attitude to have. She perceived that:

"They do not take into account what is best for the child. They just take it on themselves to bring this child up alone, children must be surrounded by the Zulu family" (Zodwa, 50, South Africa).

Another older woman, Nancy took the same perspective as Zodwa, and suggested that children brought up by single mothers did not receive enough exposure to what she termed positive discipline. In particular, she suggested that children of single mothers were not expected to react to disciplinary measures imposed by any family members, or subsequent partners of their mother. As such, Nancy expressed the perspective that children brought up in this way became wild and rude *(kuwukudelela.)* In addition, she understood that children brought up in this manner demonstrated little or no respect for older people, which she understood to be a pillar of black African societal structure intrinsic to community stability.

"Our communities, they are safe because there is a respect for others. Children are taught respect by their older relations and how to behave. When a child is not in a family, how will it learn this? It won't. Children like this a badly behaved and rude. They grow up and our communities are not safe" (Nancy, 60, Mozambique).

For some, younger women in Khaya'manzi, the influence of increasing societal change and its subsequent association with the changing influence of the patriarchal society has meant that their landscapes of fertility now includes the opportunity to be an independent and autonomous single mother. Younger women are now able to make choices about the upbringing of their children, and the influence other people have on them as mothers. However, the perspectives on single motherhood within landscapes of

fertility vary between generations. Older women understood that autonomous single motherhood could impact negatively on the upbringing of the child.

Women's Autonomy and Access to Contraception

The improvement of access to primary healthcare services in rural areas of South Africa has also had an impact on women's autonomy with regards to fertility control. It was discussed in the part A of this chapter how women's access to contraception improved between 1998 and 2003. Consequently, women's knowledge of available contraception also improved during this period. This knowledge of available contraceptives and their uses had a statistically significant association on change in ideal number of children of black African women between 1998 and 2003. Consequently, contraception, and the subsequent ability of younger women to control their fertility is now included in their landscapes of fertility.

The ever-increasing availability of contraception was evident in Khaya'manzi. During the fieldwork period, I visited primary healthcare clinics in the Khaya'manzi area, and discussed the facilities available to women with clinic staff. At that time, women from Khaya'manzi had access to three permanent government primary healthcare clinics, one women's health centre and one mobile clinic facility. Each facility was well equipped to provide, particularly, ante-natal care and reproductive health facilities.

Younger women from the community were positive about the availability and quality of care that these services offered. As one participant expressed:

"I am happy that we have such good medical services here, it is good to give women a choice about when they will have children. Our clinics have a lot of choice, and they help you to decide what is best for you" (Pumeli, 19, South Africa).

A clinic worker confirmed that the family planning services offered by the clinic had a high uptake amongst younger women. This service gave women the means by which they could control their reproductive health and time their pregnancies to fit in with their lives. She explained:

"In the past, women had no option really, now they come here and we talk about what is best for them, and help them plan for the future. Not all women want babies all the time and we can help them to plan" (Clinic sister 1).

Both single younger women, and those in relationships discussed their use of contraceptives freely. For example, Zinhle is a 24-year-old single woman, who has one three-year-old child. She wanted another child only when the first would be six years old. Zinhle believed that it was important to take responsibility for her reproductive and sexual health:

"I go to the clinic every 3 months. At each visit, I get my jova (injection, referring to depo provera contraceptive), I get tested [HIV] and I also get tested for STI's. That way I know that I am clean, I am healthy and I only have to have children when I want them …… Women like to know they are in control over when they have children" (Zinhle, 24, Swaziland).

Some women, who were in relationships used the services offered by the clinic to control their fertility without their partner's knowledge. Dora is a 17-year-old woman. She had a job that involves staying away from home during the week. She enjoyed her

job and did not want to have children yet as she believed her boyfriend would make her stop working. Her boyfriend was a lot older than her, and wanted to have children. Dora was assisted by the local clinic to find a solution to the problem:

"I went on depo without my boyfriend knowing. He wants children, but I don't want them yet" (Dora, 17, South African).

Similarly, Sunflower is a woman in her early twenties. She also did not want children until she was ready. She was single, unemployed and studying at the University of South Africa for a diploma in conservation management. She enjoyed seeing men, but did not want to be in a permanent relationship. She strongly believed that a woman should have a choice as to when she has children, if at all.

"I am on the pill, I will go off it when I want a child…. I don't see why I should tell my [sexual] partners this, it is my business, not theirs" (Sunflower, 22, South African)

Thus, it is clear that younger women are able to access contraception in Khaya'manzi with increasing ease. This is a result of an increase in access to opportunities and services and has provided both single women and those in relationships with the personal agency and ability needed to be able to control their fertility and exercise choice in this setting as it has globally. Thus the ability to make choices about fertility, and to control fertility is an important element of younger women's landscapes of fertility.

Gender Stereotyping

The preferred gender of children was important within landscapes of fertility and was a topic discussed widely by women from all backgrounds, and of all ages. Customarily,

within a community such as Khaya'manzi, there would have been a preference for male children over female children, as boys were considered superior within the patriarchal system (Ngwane 1997). Having male children meant that more credibility and community respect was given to the parents by others from the community. However, perhaps due to the influence of modernity on the community, the changing influence of the patriarchy, and the consequent increased independence and autonomy of women with particular regards to their fertility preferences in Khaya'manzi, today, this does not seem to be the case. I will here refer to observations I noted down in my field diary:

"I was walking through the village one day on my way from a morning at one of the crèches to an interview in the last street of the village. I walked past two small crèches that only seemed to open on certain days of the week, as other times I had walked past and they were closed. Today, however, the children were all playing outside despite it being a very cold day. I noticed that there must have been around 20 children, and I am sure that there were a mixture of boys and girls, but all of them were dressed in pink! Every child had at least a pink jumper on, and most had pink trousers, leggings or a skirt. The carer at the crèche was also dressed in pink too" (Extract from field diary 24.07.2012).

This was clearly unusual, and so I attempted to find out from young mothers in the area why every child was dressed in pink. Subsequent conversations with younger women and girls from Khaya'manzi explained to me that there is a general preference amongst younger generations of women from the community to have female children. Some women believed that this was a passing trend or fashion, whereas others understood it to be more of a permanent change in preference.

"I definitely am sure that today the real modern black woman wants a little girl. No woman wants a little boy, it is different now" (Nomzamo, 16 South African).

It was explained to me that changing items in the shops, and the increased availability of desirable items in female colours has meant that more women from the area prefer to have female children.

Beauty, is a 25–year-old South African, with one baby girl. She laughed when I asked whether she had any reason other than the availability of clothing for girls to prefer a female child, and said:

"Look at all the shops – Jet, Mr Price, even Pep stores, they all have pink clothes for girls and they are just so CUTE! Who wouldn't want to have a girl just to dress her up like that?" (Beauty, 25, South African).

Another young mother from Mozambique who had lived in South Africa for seven years, explained that a lot of her friends with baby boys still dressed them in clothes meant for girls. She explained that the women enjoy shopping so much for the clothes for girls that they continued to do it, even if the child is male. This means that:

"All the children at the crèches are always dressed in pink [laughs] even the boys!" (Precious, 22, Mozambique).

Thus, it is evident that an increase in the availability of fashionable clothing in shops around the area has clearly created a trend for younger women from the Khaya'manzi area to prefer female children, and children's clothing in a way always described with laughter. However, other younger women I spoke to explained the situation more seriously. It was suggested that this emergence of a gendered preference for female children can be associated with women exercising their independence and rebelling against previously constricting societal norms:

"Its fun, OK, to dress your daughter in pink stuff, but really, its like saying 'get lost' to the men, the old madalas (patriarchs) and the mother-in-laws of this community, saying you can't control me anymore, so I can do what I want, we don't need men or boys anymore" (Menenhle, 18, South Africa).

Socio-economic changes in the area have meant that many women increasingly have a higher degree of independence and personal autonomy within their landscapes of fertility. As a consequence, they are more likely to challenge the societal norms of the patriarchal society that have, in the past constrained them. This personal autonomy has also meant that they are more able to act on their own preferences with regards to having children. Whilst, evidently, women cannot pre-select the gender of their babies, they can express their great pride in their female children, dress them up obviously and extravagantly, thus showing their community their obvious delight in having a female child. Where in the past, girls would be thought of as inferior, modernity, and other forces have resulted in a reversal in gender preference of children, and rebellion against previous constricting socio-cultural norms has created an uneven preference for female children. Women from Khaya'manzi further explained how modern women had no desire to please their husbands or mothers-in-law by having a boy and this emerging preference for female children appeared to be a way of deviating from customary societal expectations and for younger women to exert their independence.

Modernity and Intergenerational Differences Within Women's Autonomy

It has been presented how women from younger generations of the community have experienced changes in their lives, and societally designated roles in many different circumstances, as a result of the influence of escalating socio-cultural societal change, which is intrinsic to the landscapes of fertility of younger women. These younger

women indicated that they have experienced an increased level of autonomy, and are now more independent, particularly in terms of their position within their respective household and their fertility choices and preferences. Older women, however, explained that they had experienced these changes to a lesser degree, if at all.

Siba is an older, South African, woman, who, when asked how her life had changed over recent years expressed the following perspective:

"I am an old woman. I am too old now to change, I have been in this household, in this family, in this building for many years. I am not moving. Not in my thoughts, not in my body… I have had nine children, I am a great, great, grandmother. I am too old to work, too old to have any more children. I am not going to be changing. I looked after my children, I was a good wife, my children have done well, they have had many children, grandchildren and other children, I did my job. I am not wanting to go anywhere else, do anything else, I sit here, and look at my family all day, I sometimes make mats and cook…. I will leave these changes to the very young ones, my great, great, grandchildren, and their children too" (Siba, 85, South Africa).

Other older women expressed similar opinions, and suggested that they neither wanted to experience, nor had experienced the changes occurring within their society and culture that had the potential to impact on their autonomy and independence. As one participant expressed:

"I don't care about this modernisation, it is nothing to do with me. I like living in my house, with my family, I love my culture" (Mbali, 54, South Africa).

However, some older participants explained that they had experienced these changes through the actions of their daughters. These had, however, mostly had negative

repercussions on their own personal circumstances and wellbeing. As one participant explained:

"I don't want independence, what can I do with that? Die alone? My daughters, they want independence, oh yes, independence from their mother and father. They don't want responsibility, they are selfish. Because of this independence that they have, that means that I will be alone" (Ellie, 70, South Africa).

Section Conclusion

Younger women experienced increased autonomy and independence because of changes in the influence of the previously restrictive patriarchal social structure and its relation to their landscapes of fertility. The changing patriarchy had an effect on women in relationships, in terms of changes in their societally prescribed roles within the family, and may have also resulted in an increase in situations of single motherhood. Single mothers in turn explained how their experiences reinforced their independence and autonomy. An increased availability of primary healthcare services has given more younger women the ability to control their fertility, through access to free contraceptives, and challenges against previously constraining socio-cultural norms has resulted in a widespread preference for female children throughout Khaya'manzi. Even within the context of the structural constraints sometimes imposed upon younger, married, women by the attitudes of older family members, and created by socio-cultural norms, younger women demonstrated agency and freedom of choice in their use of reproductive health services, which then enabled them to control their fertility, and reinforce their autonomy and independence. Thus, the changing patriarchy as influenced by modernity has had an influence on younger women's fertility preferences and the reproductive choices they make, which reflects demographic trends nationally and globally (Colleran et al 2014).

Older women, however, were generally unwilling to experience any change in their own lives and tended to express concern about how change can have an impact on the structure of their families.

4.6 The Gendered Division of Labour in Informal Caring

Care and caring roles have historically been assigned to women and female children. Female children would care for their younger brothers and sisters, and be expected to care for parents and grandparents, thus providing support and care to family members throughout the ageing process (Ngwane 1997).

The role of a carer, or care for another person is called, in Zulu *"ukunakekela"* and has specific connotations, being used to refer to the tasks that, particularly women are expected to perform to care for others in their families and their communities that are assigned to them at different points in their lives. Gendered care roles are intrinsic to landscapes of fertility. Particularly, as one participant, Ellie, explained that having female children that could participate in the household's informal caring process and share their burden of care within the household would have customarily been a strong consideration in terms of women's fertility preferences:

"Everyone wanted one female child to help in the house, it was obviously better to have boys, but for help with looking after granny, cooking, looking after children, you wanted one girl otherwise you ended up with too much work to do yourself, because as the boys got older, they wouldn't do anything. You needed the help from a girl too, and if you didn't have a girl child, you would have to wait until one of your sons got married to get the help you need in the house" (Ellie, 70, South Africa).

However, fieldwork identified that external factors, such as increasing economic affluence, more opportunities for women, HIV/AIDS and high levels of male unemployment are resulting in changes in relation to the gendered division of labour in relation to caring in Khaya'manzi.

Changes in Informal Caring

Women from older generations discussed how they had experienced changes in the manifestation of the process of informal caring within the household.

Customarily, female family members would have taken responsibility for the care of different family members, at different times in their lives. This role of a carer, is intrinsically linked with a woman's role in her family, household and community and is described by Zodwa, an older participant:

"A carer in Africa is someone who is caring for another person, who is maybe weak, or young or old…They take care of the practical needs of the person, anything like feeding and washing and things… it is expected that they do this, and the caring is meant for women and also children to do…Every child and woman in the family has caring that they must do, at the time that they are at in their life, but then that caring changes as they become older, or if they are a little boy, then they don't have to care for anyone anymore really when they get bigger… Also though the carer is someone who is known by others maybe in the household, maybe in the community, as someone to turn to, someone who will be there to help, that is what the woman is there for in my culture" (Zodwa, 50+, South Africa).

Most importantly, as Zodwa described, children are very much intrinsic to this process of care, and so it can be understood that children have a practical role to play within

their families and households within the black African socio-cultural context. Women described how conventionally, female children in particular, would be expected to perform many of the day-to-day household caring roles to assist their mothers, thus creating a clear gendered division of these roles. As one participant explained:

"To be a girl child in an African family is to take on the jobs that her mother does not have time to do… A girl must help her mother in every way she can" (Mbali, 54, South Africa).

Particularly in terms of caring, young female children would be, in general, expected to assist with care for their younger siblings. As they themselves became older and more mature, their care role would extend to include care for older family members. Later, there is the expectation that they would provide care and shelter for their own parents as they enter old age and potential infirmity, before the cycle restarts. This was described by Zodwa:

"The girls in the family look after the small ones, help the mother with the caring for them, take them to school, wash them, do their food, watch them. Then they get a bit older and can be given more to do, so they can start to look after the granny too, take her her food, clean her room, that kind of thing… When the girl child is an adult, she then has to look after her parents, take care of them when they need it, make sure that they are not alone. It is always the girl child who is relied on to make sure that the parents are OK when they get old" (Zodwa, 50, South Africa).

As a consequence of these care roles being assigned to female children, many older women I spoke to had had a preference for at least one female child as it was assumed that they would assist with care within the household, and would care for them when they were old and in need of looking after. As Zoddi explained:

"It is important to think about the future, what will happen when you get old? For that, you need children, girls to care for you, just as you cared for them when they were new to this world" (Zoddi, 60, South African).

However, some older participants indicated that there is an emerging disparity between these conventional views, and perspectives on the socio-cultural context of informal care roles in the household and the preferences of younger women from the community, whose lifestyles and choices can incorporate careers, single motherhood and often, migration away from the community where they grew up. As Ellie explained:

"I want to have my family around me, when I am getting so old that I cannot look after myself, but my daughter, she is in Jo'burg, my son, he is working away, my other daughter, she has no husband and is living in a small little room in town. All the grandchildren and great grandchildren are everywhere. There is no room for the customs of my culture in my family anymore, so what do I do?" (Ellie, 70, South Africa)

Mbali was another older participant, aged 54. Mbali explained that she felt concerned about getting older as she no longer feels secure in the knowledge that her grandchildren, in particular her granddaughters, will want to care for her and look after her when she is older, and unable to care for herself:

"As a mother, I know that I am caring for my children, as a grandmother, I hope that my children's children will care for me when I get old… but I don't think so… they won't want to care for me. They will forget how I cared for them. I don't have any money, I can't pay someone to care for me, I have to rely on kind-hearted people. It is not right. I am concerned about the future now" (Mbali, 54, South African).

Consequently, it can be suggested that many older women in Khaya'manzi are fearful of becoming old without having the customary support network of household-based care roles available to them. Conventionally, the household would provide them with care, help and security as they age and need support from their families. Thus, within women's landscapes of fertility, it can be suggested that modernity has influenced the structure of the black African family in terms of care and caring roles and created change in the intergenerational perspectives on household care. Younger women placed less importance upon the proliferation of customary household care structures, whilst older women still relied on informal care within the household. Consequently, older women described feeling vulnerable and concerned about their future and who would look after them as they became older.

The Influence of the HIV Pandemic on Informal Care

Participants of all ages expressed the view that the HIV pandemic in South Africa had affected the division of care within households in Khaya'manzi. In particular, extended periods of morbidity, high mortality rates, and premature deaths of sufferers were understood to have influenced informal care and care roles in households and the community. In particular, HIV-related ill-health of adults in Khaya'manzi was understood to have created additional roles for children of both genders and grandmothers to care for often numerous sick family members.

Women explained that male children shouldered a greater burden of care within the household because of the impact of the HIV pandemic. One participant suggested that:

"Male children are now doing the work that their sisters would usually be expected to do, and they are caring for their parents too" (Ellie, 70, South Africa).

Others explained that HIV had created additional caring roles for female children within the household and the family, particularly in terms of caring for older, sick family members. One participant described that:

"These [female] children, they are all working…These, girls, they don't get to go to school anymore, they have to care for sick grandmothers, sick babies, sick mothers… They don't have a chance to live" (Thabsile, 33, Swaziland).

Nancy, an older woman who lives in Khaya'manzi described a neighbour's illness and the consequences for the oldest child, who was a twelve-year-old boy:

"Thuli is a single mother for the last years of her life. Her husband was working away, I think on a sugar farm. He was coming back home one time about five years ago, very sick. He wasn't walking nicely, and wasn't getting out of the bed. This was strange because he was always a big man, very big muscles. Actually very handsome. She was caring for him for about six months , and then he died. She was tired, too tired and I think that was the beginning of her time of poor health. She was on ARVs, like everyone really, but they aren't always helping. . We all helped her, but… yes, it was hard for her… too much… too much… Eventually she wasn't moving. I used to see her child Thembinkhosi bringing in out the pail, very sick. . So since she's passed, Thembinkhosi is looking after the small ones, maybe two years now. He is cooking when they have food and taking them to the crèches and the bigger one walking with him to the school. Sometimes he is going to school too but I don't think much. People are helping with food. I suppose he is managing. Now, it's not right. Not right for a small one" (Nancy, 60, from Mozambique).

It was suggested that the number of families in Khaya'manzi headed by grandmothers had also increased. These are women who, it can be argued, are at a time of life where

they should be receiving care, not giving it to others. Some, like Duma migrated from their own, stable homes in other countries, with the sole purpose to provide care to other family members. She explained her care duties within her household:

"I have to care for my five grandchildren, I don't have anyone to help me. I was caring for my daughter, but she has since passed. I am now looking after these children, all are very small and some are very sick too" (Duma, 40, Zimbabwe).

This experience of the changing, gendered division of care within families and households owing to the impact of the South African HIV pandemic has had an influence on the retrospective fertility preferences of some of grandmothers like Duma. Zoddi's situation is an example of this. Her children all became sick, or had died from HIV related causes and she was left, in her old age to care for numerous grandchildren, alone. She appeared resentful and indignant, and explained to me how she was unhappy to have to care for the children so late in her life:

"[She] was wanting lots of children when [she] was young, but they were all for security. I now am left with what? One sick child, a boy child, my youngest boy. Four dead children. All their husbands, wives, girlfriends, boyfriends? Dead. And what else? I am now having eight grandchildren who are fine to care for, that is just OK, but what about the four who are sick too? How do I do this? Had I known, I would have had one child. Just one. That I could probably manage, not five, all to die" (Zoddi, 60+ South African).

As a component of landscapes of fertility, HIV is influencing the customary care structures within households and the larger community of Khaya'manzi. Male children and grandmothers now shoulder a greater burden of care owing to HIV related deaths within the household. As such, older women have described how their additional

burden of care has had an influence, retrospectively on the choices they made to have children when they were younger.

The Influence of Male Unemployment on Informal Care

High male unemployment levels in Khaya'manzi were described as having an increasing influence on familial circumstances, particularly the gendered division of childcare within the household. I will illustrate this with an example from my fieldwork diary from March 2013.

"I have noticed at all the crèches that I have visited that there are a lot of men who pick up the children in the afternoons and drop them off in the morning. At one crèche there is a man who looks to be aged in his late 20's, His name is Mandla. I chatted with him today for quite a while, he does the school run for his own two children and his neighbours three children" (Extract from field diary, 21.03.2013).

Mandla explained to me that he was unemployed, and had been unable to find work for a few years now. He was injured in an accident with a cane knife five years ago, and since then has been unable to do physical work. He described how he at first felt depressed, and found it difficult to continue, knowing that he was unable to provide for his family. However, his wife found a job as a maid in a nearby white-owned B&B, and that improved the financial situation in their household. He gradually felt strong enough to continue with his life, and took over what was his wife's role – tending the family vegetable garden and caring for the chickens and goats. His wife became pregnant with twins a year later, and when they arrived, Mandla took over the care for them so that his wife could return to her job. When they enrolled at the crèche, Mandla started walking them to and from their lessons. He noticed that his neighbour's children

walked alone, and soon began to call for them to walk with him and his children in the mornings.

I discussed this situation with women at one of the crèches in Khaya'manzi. One woman explained how the dearth of jobs for men in the area has resulted in more husbands and boyfriends taking responsibility for childcare roles in the household. Fertility choices acting in combination with the external influence of high unemployment rates for men have resulted in the creation of new opportunities and care-giving roles for men within the household.

Landscapes of fertility are thus influenced by the intersection of reproductive choices and the changing circumstances of informal caring. Informal care within the household has changed, due to the choices that younger women make and the opportunities available to them. In addition, the HIV pandemic in South Africa and unemployment of men have had an impact on informal care roles, which have in turn, has influenced women's landscapes of fertility. The increasing ability of younger women to be independent has affected change in the customary care roles in the family, creating insecurity and concern for older women, whilst HIV and male unemployment have identified new caring roles for children, grandmothers and men.

Section Conclusion

Increasing autonomy, independence and opportunities for women have had an impact on the structure of informal care within the black African household. The increasing levels of modernity that particularly younger black African women have been exposed to has ensured that they are more independent from the household, and consequently are less likely to fulfill societally-designated gendered caring roles. As a result, older

women tend to feel insecure about the care they will receive as they get older and need support.

Simultaneously, the HIV pandemic has created additional care roles for male children and grandmothers within households. Where previously, female children, and younger women would have been the primary carers within the household, extended HIV-related morbidity of adults has created this new burden of care for older women and younger male children. Thus these family members are highly affected by structural violence created by the HIV pandemic (Fassin 2007).

Yet in other circumstances, high levels of male unemployment in Khaya'manzi have influenced the gendered childcare roles in the household. Men are often unable to find work due to structural constraints, such as an absence of jobs or illness. However, households express agency when confronted with these adverse circumstances, and men take over the burden of childcare within the household whilst women work to earn the household income. This shift in the burden of childcare is facilitated by modernity, which has changed the influence of the previously male dominant patriarchal societal organisation on Khaya'manzi (Coetzee 2001:300).

4.7 Livelihood Strategies Within Landscapes of Fertility

Livelihood strategies are, often unconventional, methods used by people who are living in poverty to diversify their sources of income and to provide additional stability to unstable lives. In Khaya'manzi, the two prominent livelihood strategies outside of paid employment and the informal sector that emerged from conversations with women of all ages, were: access to the child support grant and the commodification of poverty. Children played a prominent part in these livelihood strategies, thus they are an important influence on landscapes of fertility.

The Child Support Grant

The child support grant was introduced into the South Africa welfare system in 1998, with the aim of protecting children from poverty (Makiwane et al 2006; Case et al 2005). Women from Khaya'manzi discussed the child support grant, and expressed strong views, particularly regarding its allocation and use. Perspectives and experiences of the grant varied between women of different generations and backgrounds.

This grant was described as a valued source of monthly income to many younger women from Khaya'manzi. Access to the grant made a difference to their financial situations. For some younger women the monthly grant payments were a welcome and needed source of additional income for their household.

One participant, Pansy, is a married woman, with one child. She explained how her husband was happy when she gave birth to a baby boy, however, they did not apply for the social security payment because her husband was in work and earned a good wage. Later, however, her husband lost his job and she became unwell, she applied successfully to receive the grant payment. She explained that being allocated the grant payment pleased her husband and helped their household situation:

"Because of this money, and how it is helping us, it is because of our little boy. We now call him Njabulo (Happy)" (Pansy, 26, South Africa).

Young, single mothers in particular, perceived that the grant payment was important as it provided them with a regular source of income on a monthly basis. The regularity of

the payments meant that they could be financially independent, and did not have to rely on others for financial support. This is something that allowed them to be independent of others, and bring their children up without the unwanted, perceived interference of other family members:

"I am single and I have wanted a child since I was small, I knew that having a child would give me an income. I have no need to work or to have a husband now… I can look after my child without anyone else controlling me because I have money in my bank every month…This grant means I can [bring up my child] my way " (JuJu, 19, Swaziland).

Some younger women explained that they purposefully became pregnant so that they could access the payment. Participants explained that they wanted to receive the financial stability created by the regular monthly payment. Thabsile is one such example. She is 33 years old, and a mother of three children, one 16 year old and twins, who are three years old.

"I receive income for my children, it is a good thing. I actually got pregnant with my second child [the twins] just to get the extra income. I had no boyfriend, and I needed the money, so I got pregnant" (Thabsile, 33, Swaziland).

Thabsile's circumstances stemmed from a clear need to generate additional income, in order to support herself and her family. For her, the solution to her shortfall in income was to have another child in order to access more money through the child support grant. However, there are examples of younger women who had no serious need for income, yet wanted to access the benefits provided by the additional payment and did so by purposefully getting pregnant.

These younger women perceived the grant payments as an opportunity to provide them with financial stability and perceived that the money they received was enough to support them and their child(ren) without needing to work or participate in additional income generating activities. For example, Zilly explained that:

"I didn't want to work, so I had a child…The [child support] grant is my income. I don't need to work because I know that this payment is coming in every month" (Zilly, 25, South African).

In one case, Thobile, who is 28 years old, explained that when she had her child, a daughter, who is now seven years old, she applied successfully for the grant. When her daughter got older, and started primary school, she no longer wanted the responsibility of looking after her, so she arranged for her to live with her grandmother in a village a few hours bus ride away from Khaya'manzi. Instead of changing the details of the residence of the child so that they grant payment could be paid to her mother in order to contribute to the expenses of her daughter's upbringing, Thobile kept receiving the payment into her own bank account. She explained:

"I am not going to give my mother the money, it is my money. I had the child. My mother must look after her, it is her responsibility as a grandmother… this payment means I am the independent woman" (Thobile, 28, South Africa).

I observed other situations where older women, mostly grandmothers, cared for their grandchildren on a full time basis. However, similarly to Thobile's situation, the child support grant payments were still paid to their daughters. Participants explained how they were expected to care for their grandchildren, without any financial contributions from their daughters.

"My daughter, she pays me nothing. I know there is the grant payment, but that goes to her, she tells me she isn't receiving it, but I know she is the liar"(Willow, 60, South Africa).

As such, older women expressed concern about how some younger women spent these grant payments on themselves instead of using them for the benefit of their children. In particular, it was suggested that these circumstances could lead to feelings of discontent within families.

Thombi's situation was one such example:

Thombi is an older women aged in her early sixties. I visited her and she told me about her circumstances. She explained how she cared at her own home for her seven grandchildren. For five of the children, her sons supported her and paid out of their monthly salaries for the daily expenses she incurred whilst the children were living with her. However, her daughter who was the mother of the two remaining grandchildren did not work, but received the child support grant payment each month for the two children. She did not contribute anything financially to Thombi's household, despite the grandchildren living there full time. Thombi felt exploited and frustrated by the attitude of her daughter, which she understood to be similar to those of her peers (Extract from field diary 05.02.2013).

Thombi explained:

"This is exploitation, young women today have no morals, they are using the money from the government for the wrong reasons. If they have a child, fine, get the [child support] grant, but spend it on food, school payments, things like that for the child. Don't go and spend it all in stores on clothes and hair extensions or wigs… It is bad to

expect me to look after her children and not help me with the cost" (Thombi, 64, South African).

Some women associated having children with access to money and material possessions. Participants explained how having children and consequently receiving the social grant payment afforded them access to credit from banks and shops, as it provided a steady, monthly income indicated in a bank statement. As one participant explained:

"African Bank is good for giving you money, as long as you have a little bit going into your bank account at the end of each month. For me that is the [child support grant] payment" (Alis, 30, South African).

Other younger women described how they use their grant payment to pay for material possessions such as their DSTV (satellite television) bill, furniture accounts, clothing accounts and supermarket accounts. Belinda is a single mother, aged 31. She enjoys the material benefits that she can access because of the grant payment she receives each month for her child.

"I want to have another child to get more money, it means I can have better things in my house because I can pay it off every month" (Belinda, 31, South African).

The child support grant is seen as an important, regular contribution to the financial circumstances of younger women. In Khaya'manzi, there are numerous ways that younger women and girls are taught about the grant, and its availability and how to access it, as well as the benefits it can provide to them. Nomzamo and Nobuhle are 16-year-old girls, who are still at primary school. They claim that they learnt through different channels about the benefits of the child support grant, and how having a baby

can be a financial advantage to young women. Nomzamo and Nobuhle explained how they are taught about the grant in LO (life orientation) lessons at their primary school.

"I was taught at school last year in my LO lesson that it is a good idea to get pregnant and have a child. That way we can get the money from the government that we are entitled to receive" (Nomzamo, 16, Swaziland).

Nobuhle also added that as well as through school, older girls in the community taught younger ones how the system worked:

"You learn from your older friends, get a man, get pregnant, get the [child support] grant" (Nobuhle, 16, South African).

This access to grant payments, and the attitude of younger women towards having children in order to access the payment can be seen as a livelihood strategy, aimed at promoting income stability for themselves and their children. However, this process is seen by many older generation women from the community as being "irresponsible"," immoral" and "fraudulent". It was also understood that the teachers who tutor younger girls and women to have children to access this payment are "irresponsible". Mina is a grandmother who found the situation upsetting and expressed her anger and concern, particularly over the situation at school:

"It is TERRIBLE. My grandchildren they come home from their lessons at the school here and they tell me their teacher tells them to get pregnant to get the [child support] grant. It makes me so cross I want to scream at the stupid little teacher" (Mina, 60, South African).

Khaya'manzi, like many communities in South Africa has a large number of resident migrant workers. Some are documented, and others are non-documented. Despite the constitution of South Africa stating that all residents of the country, regardless of status have the right of access to social security (South African Constitution 1996), the implementation often differs from this. When applying for social grants, applicants are asked to provide an identification document. If this cannot be produced, often applications are turned down. A Department of Welfare official verified this situation but requested not to be quoted in the thesis. In this circumstance, migrant younger women who wished to access the child support grant often turned to the services of a grant-maker for assistance.

Grant-makers, were women from the community who acted as grant-brokers. Grant-makers, usually through use of contacts in the Department of Welfare accessed payments for other people, and charged a commission per month for doing so. This acted as an income-generating activity for them, and provided women who otherwise would not have been able to access the monthly payments with some financial security. Whilst this could, from some perspectives be described as fraudulent, it is also a survival strategy that many younger, particularly undocumented migrant women depended on, and was, in many cases the only method these women could access the child support grant.

Precious was a younger participant who originated from Mozambique. She explained that she felt uncomfortable applying for the grant from the Department of Welfare. She understood that as she was an undocumented migrant, without any form of identification even from Mozambique, her home country, she would be refused access to the grant, and then later punished for being in South Africa illegally. She explained that instead of applying officially through the department for the grant payment she asked a woman known locally as a "grant-maker", to apply for the grant on her behalf.

"I am not from here, and I got pregnant by a cane cutter who was from the South Coast. He was just here for the [cane cutting] season. I only have work sometimes, I am not really well anymore so I am unable to work every single day. I had to get the grant to support my child, but I have no ID at all, not even from Mozambique, so I asked a grant-maker, she gets it for me and I pay her R100 per month out of the payment…I manage like this" (Precious, 22, Mozambique).

However, older women from Khaya'manzi expressed strong, mostly negative opinions and views about the "grant-making" process. M'du, an elderly lady, explained the situation from her perspective:

"You have these women they call them the 'grant-makers' they talk to people at the Department of Welfare and they help other women get the [child support] grant if they can't themselves. It's not good, it is making a business out of people who are poor and who can't help themselves" Mdu, 72, South African.

Rebecca, who herself used to receive money from a grant-maker for her grandchildren before a community worker assisted her with her application for a South African identification document, felt angry that she was "exploited" in this way, and that many of her friends and neighbours were still being exploited like this.

"It is underhand and really a criminal thing. These women [grant-makers], they are my age actually with no morals. They con the government, they are corrupt, they make money from people who are poor and they teach our young girls the wrong things" (Rebecca, 50, Mozambique).

Social grants, of which the child support grant is an example is a structural support system implemented by the department of welfare. Younger, South African women exercise agency and demonstrate their ability to cope in adverse circumstances in their receipt and use of the monthly payment despite disapproval from older household and community members. However, for younger migrant women suffering from situations of structural violence instrinsic to their, often undocumented, migrant status, it is often difficult to obtain. In these circumstances, they demonstrate personal agency in their use of grant-makers in order to receive the payment and access this livelihood strategy which enables them, in turn, to cope with their circumstances. Thus it can be suggested that having children, and associated access to social grant payments are intrinsic to landscapes of fertility.

The Commodification of Poverty

The commodification of poverty is the exploitation of situations of poverty with the aim of generating an income. In South Africa, because of the prominence of the white tourist trade, this is a process that is becoming more and more popular, as tourists are willing to pay to have a community experience of the lives of poorer black residents (Weckesser 2011).

In Khaya'manzi, the commodification of poverty was clearly used as a livelihood strategy, by mostly single mothers in order to generate an additional income for their household in the face of poverty, and often ill-health. The role of children was pivotal in the success of this process. I will here refer to an extract from my field diary about an incident that occurred in January 2013.

"*When I arrived at the home of an interview participant at the pre-arranged time, I was met, not by Fikhile herself, but by her 5-year-old son, dressed in what can only be*

described as rags, sobbing loudly. He was sitting outside the door to the RDP house that belongs to Fikhile. A house that she was given, free of charge by the government in 2006, complete with access to Eskom electricity supply and a hot water heater. As I approached the entrance, the child started wailing and whined:

"A fauna mali mama, mena umbilo gakhulu. Lo mamawam inigile mena uguhle" (I want money mummy. I'm very hungry. My mother doesn't give me any food).

There was no sign of Fikhile anywhere, and I clearly remembered on my previous visit a well-stocked kitchenette taking pride of place in the living area of the home. I was certain this same child was previously dressed in smart, clean, new-looking clothes, as were the rest of the family in excited anticipation of a visit from a mhlungu (white person).

I didn't have long to ponder the situation, or, for that matter, answer the child. Minutes later, the next-door curtain twitched, and I heard a loud cackle of laughter from Fikhile's next-door neighbour – an older lady called Dudu, who I had interviewed the previous week.

"My sister", she laughed. "He's having you on. He's taking a chance with you, because you are the mhlungu. This is what these children learn from young women now, they teach them how to beg, how to lie. It is funny to see, but it actually it is wrong".

By this time, two other older women from the area who I also recognised had joined us at Fikhile's house and were laughing along with Dudu.

Fikhile eventually opened the door to her home, looking as if she had been in the bath, and chased the child off the step, telling him to get washed and put on some decent clothes. She looked slightly sheepish but laughed along with us.

Fikhile told me later in the interview that she, and many other black women with young children often told the little ones to beg from mhlungus, to cry poverty, in order to raise funds for the household. It is a profitable 'business', and she herself makes a relatively large income from her youngest child in this manner.

In this instance, the child had seen my car driving down the road in the direction of Fikhile's house (it is a Toyota Hilux double cab – a typical vehicle favoured by white people who live in the area) had taken the initiative and quickly rushed to get 'in costume', ready to hopefully elicit sweets, a cash donation or food from me on what he thought would be my way past the house. Unfortunately for him, I had stopped at his house for my appointment with his mother. Not wanting to lose face, he had continued with his charade, to the amusement of the neighbours and embarrassment of his mother" (Extract from field diary 25.01.2013).

Fikhile discussed how she and her friends used their children to receive donations from tourists or locals, who were white and wealthy. However, whilst the older women found the drama amusing to watch, they often explained how the process made them feel ashamed and unhappy. Some felt that it was wrong for younger women from their community to make money in this manner. As Zodwa explained:

"We are old now, we lived through many bad times in this country, but we <u>never</u> sent our children out into the streets… we had our pride which young women do not now. It is not fair on the children, and it gives our people and our culture a bad name" (Zodwa, 50 South Africa).

Other younger women from the community described their own experiences of using their children to make money in this way. Victoria was 28 years old with three children. She lived in an RDP house, and had a husband who worked as a miner. They had a good household income, but in the gaps between receiving his income payments and his infrequent visits home, she used her children to acquire extra income:

"It helps me to have more money, and my children get it. I send them down to the boats looking a bit poor and they get money. Sometimes the tour guides give them food too" (Victoria, 28, South Africa).

This use of children for income generation in a manner, which is understood by some older women from the community to be immoral, can be a cause of disagreement between women of different generations. It is a particular cause of shame and embarrassment to many older women from the community, as they do not believe that there is poverty extreme enough to justify begging anymore.

"You see these women, they have no pride, no DIGNITY. How can they pretend that they are so poor that they dress their children half naked in rags? Leave this to the people who really are poor" (Zodwa, 50, South African)

Section Conclusion

Children made an important contribution to the livelihood strategies employed by women in disadvantaged communities, of which the commodification of poverty is an example. Poverty is commodified in order to safeguard women's and household's survival in times of hardship, poverty and often ill health. However, examples have shown that this is often a cause of anger and concern to older women within

Khaya'manzi. This could be because of the experience of poverty and structural violence during Apartheid of older women, in comparison to younger women who have grown up in a democratic country. It can, therefore, be suggested that poverty and survival often have an influence on the reproductive choices of women, as both concepts are intrinsic to the need to cope with the challenges of daily life in this context. Thus, within landscapes of fertility, women from different generations feel differently about their survival and coping, and how this intersects with their children.

4.8 Conclusion

This chapter has addressed the research question: What are women's intergenerational understandings of landscapes of fertility within the changing socio-economic context of rural South Africa?

Part A of the chapter presented quantitative findings from the statistical analysis of SADHS data. This provided evidence that women's fertility preferences in South Africa are subject to change over time. In South Africa, the five-year period between 1998 and 2003 was characterised by extreme socio-economic and political change, during which women were exposed to increasing levels of modernity. Consequently, access to education, place of residence services and understanding of family planning may have improved. These are structural changes that came about through increasing modernity, and are structuralist influences that have shaped women's landscapes of fertility. These changes may, in turn, be associated with the reduction in fertility preferences demonstrated in the quantitative analysis (Bongaarts 1990; Schwartz 2009).

Women's perspectives on their landscapes of fertility were, however, complex, and women from different generations held contrasting views on the topic. This is possibly due to the changing socio-economic context of the country that women from different

generations have experienced. The perspectives of women from different generations, about their fertility, which were relevant to the reduction in ideal number of children reported in Part A, were explored in further detail in part B of the chapter. Part B presented the qualitative findings pertaining to intergenerational understandings of landscapes of fertility in the context of the changing socio-economic context of the country and how women's perspectives about their fertility changed over time.

For many older women, black African socio-cultural norms were described to have a strong influence on their landscapes of fertility. The behaviour and negotiation of these norms by older and younger women, is, equally important in their landscapes of fertility. As prescribed by these norms, older women perceived that their role in having children was important in terms of the past, present and future of black African households and greater society and thus intrinsically linked to the concept of time. Socio-cultural norms were an enabling element of the landscapes of fertility of older women, as they felt comfortable living within the structure these provided to their lives. However some women found it difficult to conceive. These, particularly younger, women who lived within a black African household, were then unable to behave in accordance with the prescribed socio-cultural norms of black African society. Thus due to the subsequent attitude of older women to younger women, these socio-cultural norms were a source of negativity within their personal landscapes of fertility.

There is an increasing access to services and opportunities for women in Khaya'manzi. In particular, improved medical services and reproductive health services have had an influence on women's landscapes of fertility. In addition, the influence of the patriarchal structure of Khaya'manzi's society has affected change in some black African socio-cultural norms present in the area. These have in turn influenced women's landscapes of fertility and were explored in this chapter as structuralist elements of women's landscapes of fertility. As a consequence of these changes,

women from all generations have experienced transformations in their lives and how they are able to behave. This was explored in this chapter as a humanistic interpretation of women's landscapes of fertility. Younger women were able to demonstrate increased autonomy, agency and independence and freedom of choice as a result of the decline of the patriarchal societal system and changes in associated societal norms and customs, as well as increased access to improved healthcare services. Particularly the increased independence of younger women is reshaping relationships within their landscapes of fertility and they were able to demonstrate agency in their rejection of patriarchal societal norms that were often a source of negativity or constraint to them. However, older women were reluctant to experience this change, as they felt comfortable within the customary structures of black African society. These factors are humanistic components of women's landscapes of fertility.

Informal caring within landscapes of fertility has also been influenced by these changes that have occurred in Khaya'manzi. Access to services and opportunities, HIV and male unemployment have all stimulated changes in the gendered division of care at household level that have subsequently had a structuralist influence on the landscapes of fertility of women from different generations. From a humanistic perspective, in response to these changes, households and individuals have had to demonstrate that they are able to cope with the repercussions of these changes through expression of agency and strength. However, for many older women, the structural violence created by the impact particularly increased access to services and opportunity as well as HIV on the division of care within the household has meant that they have reassessed their previous fertility choices and preferences within their landscapes of fertility.

The structural violence created by poverty, migration and the previously discriminatory Apartheid regime has also influenced the landscapes of fertility of women of all ages. Within this context, the social welfare system through which women were able to

access grants like the child support grant and others in order to help support their children has an important influence on landscapes of fertility. However, women' access the grants, and use the payments in complex manners, and their demonstration of the ability to cope in the context of adverse circumstances, through use of survival strategies, such as the commodification of poverty, in which children play an integral role in their landscapes of fertility.

It can, therefore, be suggested that women from different generations, inevitably, inhabit landscapes of fertility that vary. Women's perspectives on their fertility and related choices are multi-faceted and complex and can be understood to change over time. Women's landscapes of fertility are also influenced intrinsically by the changing socio-economic context of South Africa. From a structuralist interpretation, women's landscapes of fertility can be influenced by the concept of time; the changing influence of the patriarchy on society; modernity; care and poverty, whilst concurrently, from a humanistic perspective, women's landscapes of fertility are influenced by women's experiences, their ability to cope in adverse, negative circumstances and how they ensure their survival day to day.

This chapter explored a number of themes that emerged from the analysis of the data, which provided an insight into women's intergenerational understandings of their landscapes of fertility. Chapters Five and Six of this thesis will address other aspects of fertility preferences through the second and third research questions that relate to the intersection of migration and the South African HIV pandemic on the landscapes of fertility of these black African women in Kwazulu-Natal Province.

Chapter 5: Migration Through Generations: The Fertility Preferences, Choices and Consequences of Migrant Women

5.1 Introduction

This chapter addresses the research question: How do patterns of migration intersect with women's landscapes of fertility? In doing so, I use data drawn from ethnographic fieldwork and interviews with migrant women of different generations and a key informant from a sugar farm in the area. The chapter builds on the landscapes of fertility of women that were explored in Chapter Four in order to consider the intersection of these landscapes with migration. The chapter examines the perspectives and experiences of migration of younger women and their mothers and will thus extend understandings of migration. The chapter further addresses the complexities of migrant women's use of livelihood strategies for coping as a component of their landscapes of fertility in rural South Africa.

The first section of the chapter examines women's lived experiences and accounts of the migratory process. The second section focuses on younger women's experiences of migration to Khaya'manzi. In the final section of this chapter, I examine how older women are migratory followers of their children, and argue that this extends the concept of migration.

5.2 Views and Experiences of Migration

Migration to Khaya'manzi and also other urban and rural areas in South Africa is popular because of the perceived promise of a relative abundance of jobs in the extensive farming and tourism industries in the area, as well as its close proximity to

international borders with Mozambique and Swaziland. In the years since Apartheid ended, with the lifting of restrictions on the movement of black African people, large numbers of economically active women of working age and ability have migrated to Khaya'manzi and the surrounding areas. These migrants typically crossed international, provincial and district borders from resource poor areas as distant as Mozambique, Swaziland and Zimbabwe, Mpumalanga province and other districts in KwaZulu-Natal, and finished their journeys in Khaya'manzi. There is both internal migration within South Africa and international migration from other countries[9]. The qualitative data presented in this chapter is primarily about international migratory experiences rather than internal migration within South Africa.

Interviews with women revealed that the process of migration is embedded in long-standing household and community patterns of migratory behaviour. Participants explained the importance of migration to their home communities, in terms of financial support provided by remittances sent back to families and the role the migration of friends and neighbours played in inspiring younger community members to migrate. Women also discussed their feelings of anticipation related to their own participation in the process of migration, and how their own migration may have influenced perspectives on their fertility preferences and choices.

Participants discussed how remittances had a positive effect on families in their home communities in terms of increased disposable income for purchase of modern goods and improved living standards and conditions. One woman described how remittances sent back by her mother to Swaziland helped her extended family:

"Our money paid for a brick house to be built for my grandparents, they have bought chairs, beds, tables, stoves, linen, curtains, better food… they have savings in a bank

[9] Migration in South Africa is discussed in further detail in chapter 2.

now… Once when my young brother was sick, they could afford the ambulance coming to the house... It has changed their lives" (Nomzamo, 16, Swaziland).

Another participant described her experience as a child of being part of a family receiving remittances from an older sister who had moved away to find better employment opportunities.

"The money was received usually in the first week of the new month…when the SMS came from the bank saying that money had been deposited, my mother would put on her nicest clothes, and go into town. She always bought us school things first, then mealie meal, sugar, tea, beans, samp and sweets, and if someone needed a new pair of school shoes…Anything left over was saved, and she used it to buy bricks, cement, windows… Gradually, we built a house" (Nobuhle, 16, South Africa).

Disparities in levels and frequency of remittances received by households often produced rivalry between families, because of subsequent material inequalities created between households. These inequalities were visible in terms of the materials used to build homes and clothing worn by the families as well as purchase of vehicles and livestock. As Precious described:

"I used to see women buying the newest stuff for their kids, new clothes from the expensive shops. Neighbours used to try and do better than each other… build bigger and better, with brighter colours. That sort of thing… Every month, this one family used to go to town and buy cows or a tractor, then the next month their neighbours would come back with a plough some goats or a new bicycle, just to prove who had more money" (Precious, 22, Mozambique).

Experiences participants had of observing the migration of others influenced them in their decisions to migrate, and particularly those from younger generations, were exposed to the benefits of the process of migration, and would later migrate themselves in order to experience this perceived affluence. The benefits of migration were described by Menenhle, who stated, *"Me, I wanted nice things. I could only get that if I moved away" (Menenhle, 18, Mozambique).*

In addition to the material benefits, some participants were inspired to migrate after hearing stories about South Africa from family members and neighbours. Thabsile explained that she moved to South Africa away from her home community in Swaziland because she wanted to experience new situations and see other places. She explained:

"Seeing it [migration] gives hope, hearing stories about people who have moved...It helps people back home understand that there is a bigger world out there than the little village we know… I moved because I wanted to see this, to have more of an experience of life that is not just my small village" (Thabsile, 33, Swaziland).

Participants discussed how, in areas where out-migration for labour was a long-established process, there was the perception amongst younger generations that migrating provided access to wealth, better living conditions, modern clothing and commercial items.

Precious was one participant who had wanted to move away from her home in Mozambique since she was young. She discussed her experience of migration with me in detail. This is a field diary extract that was written after I spent time with Precious discussing her experiences:

Precious perceived her home life to be typical of many in rural Southern Africa: she shared a hut with her sisters, and left school when she was fourteen years old to care for her younger siblings. On a daily basis, she would fetch water for the household, tend the vegetable garden (mashamba) and fish for mackerel in nearby lakes. Her mother had never worked but her father was occasionally employed on a nearby farm owned by a white person. Her family had livestock and chickens, and enough land to support the family. The income her father earned was enough to buy household necessities, medicine when needed and rice every month. She understood that the family was relatively well off, and well thought of within their community. However, Precious, wanted to access what she thought would be better opportunities (extract from field diary 9.12.2012).

Precious described her experiences:

"I finally moved over after many years of waiting in 2007. I had been wishing for that day for a long time, and finally it came. I was so happy. I remember so well that morning when I finally jumped in the minibus taxi (chappa) and headed down to Maputo, where I was going to get the transport through to the border and then into South Africa. People from my village had gone there before…mostly men really….They came back to visit with lots of nice things for their houses and clothes for their wives. I wanted that too and thought South Africa was where I could get that money to afford those things" (Precious, 22, Mozambique).

Women like Precious expressed the view that migration away from their home communities had the potential to provide them with access to income, and a better life for both themselves and their families back home. However, some participants referred negatively to the unknown that is associated with migration. It was suggested that a

lack of knowledge about the situation made people unrealistically positive, whereas the reality is actually very different. As one participant expressed:

"All we see back home is the money that comes in. Actually, if you are really thinking about it, it isn't really a lot of money, it is just that things are so cheap out in the rural areas, and outside the borders. We never see the people who move again, they just stay away, always sending this money. That is why the young ones they are thinking that it is better to go away and have this life…. They don't know this though…. They don't know what it is really like to do it. (Rebecca, 50, Mozambique).

Other women described their concerns about friends and neighbours who had migrated, mostly men they had known, who later returned to their home communities to die. However, one participant, Thembeka, explained that whilst she remembered this happening, it had not affected her own desire to migrate, and years later she still moved away to South Africa:

"This man died and suddenly everyone was talking bad things about South Africa… Later though, it was all forgotten really and we all still moved away… Even if people died from South Africa, at least it was better than sitting at home dying slowly like we did in Zim" (Thembeka, 24, Zimbabwe).

Despite the negative experiences of the migratory process that some participants encountered whilst still living at home, women explained how they had wanted to bring up their children in South Africa, so they could ensure access to better opportunities for them too, both in terms of education and material living conditions. As one participant suggested:

"Knowing there is this other world out there where our neighbours go to and don't come back, but send money… this is what we want for them [our own children] to experience…nice money, nice houses, nice schools and smart [school] uniforms. It is because we don't know for sure what is there, that we can dream for them, for our children" (JuJu, 26, Zimbabwe).

Major life choices, of some participants, like being in relationships and having children were described as being reliant on successful migration experiences. Some women explained that whilst they worked and saved, and waited to acquire enough money to fund their migration, they refused to react to attention of local men. Most preferred to wait until they had successfully migrated before finding a partner and entering into a relationship. As one participant expressed:

"I didn't want a boyfriend, didn't want to get pregnant and have to stay behind. I wanted to move to South Africa for a new start. I didn't want the stress of getting in a relationship and then leaving" (Dinance, 30, Mozambique)

Dinance hadn't wanted to enter into a situation where she got pregnant before leaving home. Zinhle also felt that if she had become pregnant before migrating it would have been an unwanted burden. She explained how having children would have hindered her ability to migrate easily, and if left behind would have been an unnecessary expense for her family:

"I can't leave a child behind, and if I could, my mother couldn't afford to support another grandchild" (Zinhle, 22, Swaziland).

Making these decisions such as not to have children or enter into a relationships before moving away often meant that women felt alone. As Princess explained:

"I didn't like my home because we were poor…I didn't want to have a boyfriend, have a family in that place or make friends, because there was no point, I was moving away…I was cold, hungry and by myself much of the time" (Princess, 24, Zimbabwe).

Despite holding these strong opinions about having children and entering into relationships, women often changed their minds during their pre-migration period. Despite not wanting to become pregnant whilst still living at home, some participants indicated that when they reached the financial target needed to facilitate their move, they started planning for their personal futures. As one participant described:

"I remember the day when I got my last bit of money that I needed. I was so excited, I was talking and planning my journey with my friends, and we were dreaming about what life would be like in South Africa… I planned to have a nice South African boyfriend, who would marry me at a church. I wanted to have three children, twins and another little girl" (JuJu, 26, Swaziland).

However, some women suggested that with hindsight, they would have preferred to have children before they moved away. Participants believed that this could have been positive for them, instead of the previously perceived burden and obstacle in the way of achievement of their life plans. Participants explained that having children and leaving them behind at their family homes may have been an incentive for them to return, rather than stay in South Africa without employment and in poor health. As one participant explained:

"I never wanted to have children, I just wanted to move away… When I got here I got sick, I think maybe if I had children before I would have stayed, or at least returned,

then I wouldn't have been stuck here with no job, poor health. It would have been better for me" (Princess, 24, Zimbabwe).

Women, particularly those who had children after moving to South Africa, often discussed feelings disappointed as they felt unable to provide opportunities for their children in the ways they had dreamed of whilst still living at home. For example, Tilly is undocumented. This meant that when her first son was born in South Africa, she was unable to register his birth because she couldn't provide identification. She now believes that:

"[I] can't give him opportunities, he doesn't have a birth certificate, this means he can't get an ID when he is older. Without an ID, you can't do anything in South Africa. It would have been better for him if I had have stayed at home" (Tilly, 23, Mozambique).

Thus, some thought that they failed their children: far from receiving the opportunities and the better life they thought they could provide if they migrated. Many understood that they have had children who are now vulnerable to disadvantage and sometimes they saw this being as a result of choices they made. As one participant expressed:

"It is my fault, it is not fair on my child. He has never done anything, if I had had him at home, he would have been far better off. I shouldn't have made choices that affected the child" (Princess, 24, Zimbabwe).

However, as one older migrant woman explained:

"They forget. Here, they can manage, get cash through a grant-maker or something. At home, we are poor, there is no water in drought, there is no food often, we don't

have cars, we walk for miles, people get sick and we travel hundreds of kilometres to the hospital, not just five minutes down the road to the clinic. They miss their families, so they look back and believe everything was good, but actually when they were there they hated it, that is why they moved away" (Jilly, 41, Zimbabwe).

Section Conclusion

Prior to their own migration, women mostly thought that labour migration of men, women and couples of working age was a positive process, as it was understood that it could be beneficial to home communities, the families left behind, the migrants themselves and their children. Witnessing the increasing affluence of families in receipt of remittance payments increased the desire of younger generations of women to migrate, and acted as a pull factor motivating their migration. Out-migration has also proliferated across generations in areas, which historically have had high levels of out-migration, because of the structural violence experienced by women in their home communities. Women described lives in home communities as poor, hungry, lonely and without access to basic health and other facilities, therefore conditions that are synonymous with structural violence. This was a push factor that motivated their migration to Khaya'manzi. Often, women from these situations desired a better life for their children, living or as yet unborn and expressed agency in their movement away from their home communities in order to achieve this. Thus migration intersects with women's landscapes of fertility. Many women moved as migratory leaders from their households, which is indicative of the feminisation of the process of migration. However, many female migrants, on reaching Khaya'manzi, encountered hardships, difficulties, and poor health and essentially moved from one situation of structural violence into another.

5.3 The Experience of Migration

As discussed in the previous section of this chapter, most younger women had long-anticipated migrating away from their home communities. However, many described their actual personal experiences of migration as far from the long-awaited, exciting event that they had imagined. Participants described difficult, unsafe journeys and how they felt vulnerable and scared when they arrived in Khaya'manzi. The only job opportunities available to them were hard, manual labour, for low wages, and living conditions were poor. Thus they encountered situations of structural violence. In order to negotiate this structural violence, many women displayed agency and demonstrated that they were able to cope with these situations through use of livelihood strategies, which often posed a risk to their health.

Menenhle migrated to Khaya'manzi from her home community a number of years ago. She was very young when she left, and travelled alone. The journey to Khaya'manzi took seven days of difficult travelling. She hitch-hiked lifts from trucks, took minibus taxis where possible and walked great distances. She slept when she could, at the side of the road, and in vehicles when travelling. She explained how she took a great many risks, and as a consequence was extremely vulnerable as a young female travelling alone. She recalled her fear when she slept alone on a roadside in the dark, while she waited for her next lift:

"Most of the time, I didn't know where I was, I had no knowledge about the safety of the area. I would put my money and my cellphone in my bra, and wrap myself up in layers of clothing. I would sleep very lightly and wake up at the smallest sound….I was also worried about malaria…Usually you are sleeping inside at night, you are safe…I was very, very scared" (Menenhle, 18, Mozambique).

Participants discussed, not only their feelings of vulnerability but also their experiences of anxiety and fear caused by travelling through places they did not know. One participant described how she ended up travelling a long way in the wrong direction, because she wasn't aware of the route she should take, and places to stop along the way to change minibus taxis.

"I really thought I was lost, I had gone to Zimbabwe or something. I took the wrong taxi and I ended up the wrong way… Because I didn't know where I was I just carried on, when the taxi stopped, I asked how to get a bus to the border and they laughed. We were a long way from any border! I was scared… I didn't know where to go… it was an expensive mistake… I was going around in circles… It was hard to ask people to help me… I was really lost" (Precious, 22, Mozambique).

On reaching Khaya'manzi, after their often long, expensive and uncomfortable journeys, women felt tired and overwhelmed. In most cases, they arrived after dark, and had no knowledge of where to find safe accommodation.

"I was so alone, I missed my family, my sisters, my friends. I had no job, I arrived when it was dark and I knew no one. I didn't even know how I would find a job in the morning. I wished I could have gone back home" (Zinhle, 22, Swaziland).

Zinhle's feelings are typical of women who discussed their individual experiences of the migration process. Often, these newly arrived migrant women managed to find either expensive, overpriced rooms or poor quality beds or half beds in crowded, mixed-sex dormitories. As one participant described:

"I arrived, and had no idea where I was, I didn't know anyone, I just found myself at a taxi rank. There was a row of rooms there with a sign saying accommodation available and I was so tired, I just went there to get a room for the night, I paid over R400 for the private room with no mattress or anything" (Princess, 24, Zimbabwe).

Although Princess was unhappy about paying what was relatively, a great deal of money for a very basic room for the night, she was however, safe. Dinance had travelled to Khaya'Manzi from Mozambique, and also explained how she arrived late at night. However, she didn't have the money to spend on the expensive accommodation by the taxi rank, so asked for directions and walked about three kilometres to a cheaper establishment. Her experience of her first night in Khaya'manzi was very different:

"I paid for a bed in a bunk house, and walked in, I was so very, very tired, I just wanted to sleep. But I got inside and there were four men and another woman… They were loud, smoking, playing music. The woman was naked, and the men were having sex with her. I think she was a sex worker…Later they started talking to me, and saw I didn't know Zulu, so they were teasing me, the woman stole my spare dress from my bag and the men pulled my money from my bra. It was only R50, and I was lucky I had more hidden" (Dinance, 40, Mozambique).

Some women described their experiences of arriving in Khaya'manzi and finding shelter under tables of stalls set out around the taxi rank. Here, drunk men, people taking drugs and sex workers (*nthombi*) disturbed them and made them feel vulnerable and unsafe. As one participant described:

"I just curled up on the ground in my small blanket, on top of my bag and tried to sleep… A drunk man fell over me and put his face next to mine, he was breathing all over me, it was disgusting, then a sex worker took a customer to the table next to mine,

and there were people taking drugs all over the place, walking around with that funny look… I felt so scared, and worried they would rape me or steal from me" (Thembeka, 24, Zimbabwe).

In general, the young women felt lost, confused, and exhausted when they arrived in Khaya'manzi. This meant that they were vulnerable to exploitation and exposed to high-risk situations. Some participants described how their exhaustion and loneliness led to them accepting offers of employment of dubious legitimacy:

"I needed money, fast. I had spent nearly all my money, so when a man came up and offered me work, I took it. I didn't ask any questions, and just went with him. It turned out that I was a host in an illegal bar (shebeen), and he made me have sex with men" (Princess, 24, Mozambique).

One group of women alleged that organised groups of men in the community often targeted newly arrived, young, migrant women. They explained how when they each arrived, they were offered a place to live, wages, clothes, mobile phone airtime and food in return for working as what was initially described as a cleaner or housekeeper. One of the women described her experience:

"I was new, I had only been here one night, and some men came to me whilst I was waiting for a bus to the other side of Khaya'manzi… They offered me a good job, with a room and good money as a housekeeper, airtime and new clothes. I accepted of course" (JuJu, 26, Swaziland).

However, in reality these women were often subjected to both physical and sexual abuse, were rarely paid and were forced to fulfil year-long contracts. In general, it was described that the contracts lasted a period of a year and after that they were thrown out

of the provided accommodation and again, had to find a way to support themselves in a community they did not know well. JuJu met Zilly through her ordeal, and described her experience and how they finally managed to leave together:

"I got there, and there were two other women, we all shared a tiny room. We were all hurt a bit, we got paid once whilst I was there but they kept promising... My friend was made to have sex with men… These men said we agreed to stay for a year and made us work cleaning and stuff for a year with no pay. They let us out, but where would we go? We didn't know anyone. We eventually got kicked out and had to find a room. It's better now" (Zilly, 25, South Africa).

Newly arrived migrants were also highly sought after as manual labour on large sugar and fruit farms in the area, particularly during the cutting and picking seasons. Farm foremen visited areas known to house migrants and hired migrants new to the area. This is because newly arrived migrants were thought to be healthy and hardworking and not discouraged by poor living conditions. In most cases, they were not yet aware of the minimum wage and were still willing to work for low wages. However, their acceptance of these conditions meant that they were then exposed to situations of structural violence created by the migrant labour system in South Africa. Richard, a foreman for a large sugar farm in the area discussed this situation:

*"It is my job to organise the staff for cutting, and sorting, and burning of the cane. I need to get people who are willing to work, and who will work for the money the boss will pay. It is best that I look for the new arrivals. They always work better, they are not yet sick and they don't understand how hard the job is. Not yet. We foremen battle together to find the best ones, we get there [*to the accommodation*] early in the morning, then if I do that I beat the others and get the best workers. I'm paid with*

commission for how much we cut in a day, so it is in my interest to get the best workers" (Richard, Sugar Farm Foreman).

Often after a short period of working as a casual labourer, women described how they became tired of the hard, manual work, and aware that their pay was not enough to support themselves, let alone save or send home remittances of much value, and most accommodation available to migrants was located on farm property. As one participant explained:

"I had sores on my arms, legs, feet, burns from chemicals on my legs… I was exhausted, and worked sixteen hour days… I only got paid R30 per day. It was the only work I could get, and if I left I would lose my room" (Tilly, 23, Mozambique).

Migrant women tended to find legitimate jobs in other sectors hard to come by, particularly for those who spoke languages other than the local isiZulu. Sallie travelled to Khaya'manzi from another province of South Africa. During one interview, she described her search for alternative employment that did not involve manual farm labour. She explained how, over a period of three years, she attempted to secure different employment, but was not successful. She was from a rural area of a different province of the country and was unable to speak and understand isiZulu. Sallie believed that it was her background rather than her inability to speak English or lack of formal qualifications and work experience. Sallie believed that in Khaya'manzi, women from outside the area were discriminated against in terms of access to employment, and as such, remained restricted to participating in manual labour only. She believed that this was a deliberate ploy by farm managers to retain a pool of cheap labour, as they knew by restricting the access of migrant workers to other labour opportunities, they retained a large group of workers who were desperate and poverty stricken. As Sallie explained:

"They know that we are desperate, they know that we will do anything for some money, because we have no other option...They want to keep it like that, so they make sure that we can't move away. They know where we are and we can't get any other work" (Sallie, 26, Free State, South Africa).

Migrants from other countries described how they felt unable to complain or protest about these poor working conditions, long working hours and sub-standard accommodation. They were afraid that because of their illegal status, and, because they had engaged in employment activities without the necessary permits they may get deported or reported to authorities if they complained. As one participant expressed:

"I was scared, so I carried on… I didn't want them to get revenge on me complaining, so I didn't. If you are illegally working in South Africa, you don't really have any rights" (Tilly, 23, Mozambique).

Others were scared that they would lose their accommodation if they were unable or refused to work on the farms. They would have no place to stay, and worsen their situations.

"The accommodation is only given to workers. If you are not working, you get thrown off the accommodation. Sometimes, the white farmers even come with guns and make the foremen come too. We have to threaten them if they are there and do not have a job on the farm" (Richard, Sugar farm foreman).

Migrant women in Khaya'manzi often became trapped in situations where they felt unable to instigate change in their lives. Using a structuralist interpretation, migrant women's landscapes of fertility were influenced by the inequalities and unfairness of the migrant labour system in Khaya'manzi, their immigration status, financial situation

and reliance on labour-related housing. Younger migrant women thus regularly experienced situations of structural violence in Khaya'manzi. In order to negotiate these situations, women did what they could to cope, and expressed this ability through use of a range of livelihood strategies to generate additional income. These included pregnancy, transactional sexual relationships and accessing the child support grant through grant-makers. As one participant explained:

"I couldn't afford to live, I needed to send money home, so I started having sex for airtime, mealie meal, clothes. It meant I could send money back home… I got pregnant and I used a grant-maker for the [child support] grant payment" (Princess, 24, Zimbabwe).

Whilst actions such as these enabled these women to cope better with their circumstances, it meant that they exposed themselves to increased levels of risk of infectious disease and emotional and physical abuse.

Young women often described feelings of unhappiness and failure, as they perceived that they had failed to achieve the better life they had dreamed of. As one participant expressed:

"I haven't done it. I haven't improved my life, I have actually made it worse, I feel as though I have wasted so many years" (Precious, 22, Mozambique).

Some participants felt very unhappy about what they understood as their failed attempt to improve their lives. One participant expressed the view:

"Some days, I wake up and I just want to give up. I can't go home, I can't stay here. I have nothing… My children have nothing…What is there left?" (Pretty, South Africa).

Women often felt that these feelings of despair were reinforced by their experiences of failed relationships whilst living in Khaya'manzi. Participants described how, when still living at home, they had anticipated entering into faithful and stable relationships once they had moved to South Africa. However, for many of these women, the reality turned out to be different. Women described their personal relationships with men from the community for the most part as negative experiences. In particular, many claimed that their partners were often drunk, used drugs such as Khat and cannabis (*dagga)*, refused to contribute financially to the household, were regularly unfaithful, often abusive, and frequently put them at risk of contracting of sexually transmitted infections. Thabsile's situation was one such example:

"I am in a relationship with a man, he is not like I thought he would be. He drinks, he smokes, and he smokes dagga every day. He doesn't work, but he expects me to. At the end of the month he steals my money and uses it on sex workers, so I worry all the time about my health. He refuses to use condoms when he sleeps with me, and we already have three children… It makes me stressed that the children are from this horrible man" (Thabsile, 33, Swaziland).

Women in situations similar to Thabsile discussed the sadness they felt about their failed relationships. Many felt that they had failed their children rather than themselves. They perceived that in making what they understood to be the wrong choice of partner they had failed to provide for their children in the manner that they had envisaged before leaving home. One participant expressed the view:

"I wanted to give my children a role model, that is why I waited to find a man until I left home, and I ended up with a drunk, who smokes dagga from Maputo. I feel like I have

failed my children; my boyfriend is no father for the boys to look up to" (Menenhle, 18, Mozambique).

Women with children worried about how to take care of them, as well as earn a small income to support themselves and send money home to their families. Some also explained how their poor health, lessened their ability to work, and exacerbated their feelings of failure. Princess explained:

"I am sick, it is making it worse, I have children, I am worried all the time, I can't earn enough to care for them, to live and to send money home to my family…I have failed." (Princess, 24, Mozambique).

Anguish over their choices to have children in South Africa, and concern about their children were topics that these women frequently referred to. Some participants expressed the view that their children had been subjected to structural violence in terms of poor living conditions, disease and extreme poverty because of their own choices. This was, as one woman explained, a source of regret for her as a main reason for her migration had been to have children and provide them with an upbringing in a more beneficial environment than that she had left behind:

"I shouldn't have children here, they live in bad places, I saw that when I got here, but I thought that they would help, I could make them a life. It didn't happen like that and it is not fair, but I can't do anything to help them" (Thabsile, 33, Swaziland).

Section Conclusion

Despite long-anticipating migration, younger migrant women who were residents of Khaya'manzi often found the reality of their experience very different from their expectations. The structural violence created by undocumented statuses and the reality of migrant work opportunities meant that younger migrant women were often unsafe and vulnerable and sometimes adopted risky livelihood strategies in order to achieve their daily needs and cope with their situations.

Younger migrant women were mostly unable to radically change their situations because of institutional and societal structures that proliferated economic and social inequalities, and contributed to their situations of structural violence. These structures included the segmented labour market and patterns of land tenure, gender relations, unemployment and the status of migrants. However, despite their situations, many younger migrant women demonstrated agency in the negotiation of these structures in their need for survival. In order to cope with their situations, younger women frequently requested help from their mothers who were living elsewhere. Various participants described how they contacted their mothers back home with the request that they travel to Khaya'manzi to help with childcare and income generation. Some of the mothers agreed to join their daughters. Consequently some older women became migratory followers of their children, despite being mostly unaware of the realities of the situations of structural violence experienced by their daughters before they arrived in Khaya'manzi. As a result of previous fertility choices, numerous older migrant women in Khaya'manzi were migratory followers of their daughters and contributed to migration patterns in South Africa in what could be described as an extension or reversal of the common paradigms of migration, as whilst literature concerning the feminisation of migration has acknowledeged that women are increasingly autonomous migrants in their own right, this following section identifies that women's migratory patterns can be dual phase, and intergenerational.

5.4 Mothers and Grandmothers as Migratory Followers

Older migrant women in Khaya'manzi often moved to the community as migratory followers of their daughters. They consisted of a combination of international and internal migrants. Migrants from other African countries tended to enter South Africa initially as fully documented temporary residents and came to the country through legal border points of entry using, passports. Internal South African migrants travelled to Khaya'manzi from their home communities.

Interviews with these older women revealed varied experiences of migration to Khaya'manzi. Their participation in the informal trading sector and as carers in Khaya'manzi was a theme in many interviews, and women discussed their feelings when they realized it was unlikely that they would ever return to their home communities.

Women who moved to Khaya'manzi as migratory followers of their children thought at first that their migration to the area would probably be temporary. Few of these older migrant women were aware that their migration may become, a permanent move.

"I expected that I would stay and help… maybe… two months? I would see the children better, and see her better then come home. When I realised how bad it [the situation] was, I thought, OK well… I'll get them medicine, pay for them all to come home...I didn't realise they couldn't go back" (Duma, 40, Zimbabwe).

For the most part, women like Duma expressed the view that they had not wanted to travel to Khaya'manzi, and would rather have stayed in their home communities. However, for the sake of their family they made arrangements to visit their children, on a temporary basis, to help with childcare, income and care for sick household members.

However, not all older women were reluctant to leave home. Some women saw it as an opportunity to leave difficult environments where they had lived in poverty. The situations of poverty they left behind acted as a push factor motivating their migration. Jilly is one participant, she moved to Khaya'manzi from Zimbabwe to provide help and support to her daughter. She discussed her feelings about leaving her home in Zimbabwe to travel to Khaya'manzi:

"In Zimbabwe, it was very difficult…not really safe…When my daughter phoned, I said I would come because I wanted to get away, I had a bad house, there was no food, no work, no hospitals if you get sick. It isn't very nice there. Also, it is dangerous. I am glad I came to Khaya'manzi" (Jilly, 41, Zimbabwe).

Older women frequently discussed the difficulties they had when they arrived in Khaya'manzi to help their children. One participant explained how she searched for three days before she was able to locate her son and grandchildren:

*"I arrived very late, and there was no one around really, just a shebeen. I was lucky though, because I found a place where I could rent a room for a night, it was expensive but it is not safe to just sit around. Any criminal (*tsotsi*) can hurt you. I woke up in the morning the next day and asked and asked for anyone to help me find my son, and his children but no one could help me. Eventually after three days I found them. They were living in a room made out of plastic, horrible bad place, right near by the sugar cane. I had to ask a lot of people to find them…Their house wasn't a house. They had moved from a beautiful house at home, made of bricks, even with a proper, indoor bathroom… This was horrible… This wasn't a real house. I sat and cried before I had the courage to enter" (Zodwa, around 50, Trust, South Africa).*

On finding her children, Zodwa had to overcome her feelings of shock at the situation she found them in. She described her attempts to improve their living conditions. She explained how she used the money she had brought with her from home to mend leaks in the roof, purchased pre-paid electricity, bought food, medicines, new clothes and shoes, cooked and cleaned and cared for her son. She also arranged places at the local crèche for her grandchildren. As time progressed, she found that her money was depleted, and she had to find alternative methods of coping and supporting herself and her family financially. She also was unable to revert to her previous plans of returning home within a short period of time:

"I did all this to help, I spent all my money, and then I couldn't leave because they were so helpless and couldn't get home" (Zodwa, around 50, South Africa).

Zodwa was not alone in her experience. Another participant was Nelly. She migrated to Khaya'manzi to care for her family. She found she had four grandchildren that she had never met, an additional two children whose parents had died and abandoned them, alongside her own son, who was in the later stages of HIV to care for. Nelly described how she took on the emotional and financial burden of her new household, with no support or assistance and no friends in the area. She described how the funds she had brought with her from her home ran out and she was left with five living children who needed her care and yet she had no income, and was not aware of the state funding available to support her. As Nelly explained:

"I was new to the area, it was so difficult, because I didn't speak Zulu so well and I had no friends. I actually felt very lonely, but I had to look after these children. I didn't know that I could get this money, I just had to manage" (Nelly, 45, Mozambique).

Before they travelled to Khaya'manzi, many of these women thought of themselves as proud mothers and grandmothers, supporting and supported by their families and living secure lives. However, women described feeling regret and disappointment about the situations they found their children living in, and the circumstances they were consequently left to bear. One participant described her feelings about the situation she found herself in when her daughter died on the same day she arrived in Khaya'manzi to help her and her children:

"I am an old woman, I have no home now, I have no daughter here, she died, my grandchildren are dying...No, I now have no one. I would have been better had I just never married, never had children, then at least I would be alone but without all this sorrow." (Ember, 55, Zimbabwe).

Many older women, like Ember, Duma, Jabu and Nelly brought cash with them, to provide financial support to their children and to support themselves in Khaya'manzi. Participants described feelings anxious and worried when they became aware they didn't have enough funds to support themselves for long:

"I thought I had enough money, but the journey was very expensive. I had to pay for medicine and food when I found my daughter, and buy clothes for her baby. I was stressed that we would not have any money left and wouldn't be able to live" (Nelly, 45, Mozambique).

Nelly and Zodwa described situations where they had to draw on their personal strength, and exercised agency, in order to negotiate these structural obstacles that they encountered. They further displayed personal resilience in their ability to remain strong. They looked to alternative ways of generating income to support themselves

and their new households. Consequently, they managed to ensure their survival in their new environment. As Zodwa stated:

"[I] had to do something, there was no point crying about it. If I hadn't then we would all have starved" (Zodwa, around 50, Trust, South Africa).

Older women frequently demonstrated how resilient they were, through discussion of how they created opportunities for themselves in the informal trading sector in order to support their children's families and households. For example, Jabu is an older woman who joined her daughter in Khaya'manzi from Mozambique. She explained how every spare area of ground in rural Mozambique is used to cultivate crops such as yam (*cassava*), varieties of spinach and peanuts. When her own funds had been depleted, she noticed a large area of spare land, located close to the river that was devoid of crops. She explained how she sought and was granted permission by the farm foreman to cultivate the area. She planted seeds that she saved and managed to purchase over time that ranged from pumpkin to spinach and sweetcorn (*mealies).* She timed the planting so she would have crops throughout the year, just as she would have done when she was at home in Mozambique. She explained how she harvested the crops on a fortnightly basis and sold them at the local market, mostly at the end of the month and on pension day when people had money to spend on luxuries. Although a relatively small income, this activity provided Jabu with enough money to buy household essentials and she saved vegetables to feed her grandchildren, thus ensuring that they had enough nutritious food to eat:

"I didn't have money to buy food, but I had my skills, so I looked for a chance to use them and found one. Now we have food for our whole house, and money when there is extra to sell" (Jabu, 42, Mozambique).

At the end of the month and on pension day, when government grants were distributed and wages paid, Jabu and other older women often sat outside the trading store and sold items such as vegetables, clothing, herbs, curry bush (*mphephu*), second hand shoes and handmade items like sleeping mats (*thansi),* baskets and strings of teething beads. It is here that I first met across these women. Here is an extract from my field diary from when I first met Jabu and three other women:

"Today I spent the morning at the church crèche. It was extremely hot, and there seemed to be a lot more children there than usual. I helped the women with the children's play and their lunch, and whilst they were having their sleep sat outside in the shade on a mat.

*I walked over to the trading store to buy a drink, as there was no water at the crèche today. It was extremely busy there too, the bar (*shebeen*) was busier than usual, and there was a queue for the checkout at the general store. Men and women were sitting in groups on the stone benches outside the tavern with bags of shopping and bottles of beer. I noticed there were four older looking women sitting on mats outside the door to the tavern under the trees, and walked over to say hello, hoping to sit next to them in the shade whilst I finished my drink. As I walked close to them, one called out to me: "Sister, come here! Today you are hot! Would you like some spinach or potatoes?"(*sesi, woza! uShisa namhlange, ufauna maspiniche noma'mazambane?*). I bought a bunch of spinach and a string of beads and asked if she would mind me sitting with them for a while.*

She said her name was Jabu, and introduced me to her three friends too. I asked them where they came from, as I noticed they spoke amongst themselves in Chope or Xitsu, which are distinctive languages from central and north Mozambique. Jabu explained that they were all from Mozambique, and had moved to Khaya'manzi to be with their

families. They were surprised that I understood a little Chope, and I explained that I had lived in central Mozambique.

*We sat talking until it got dark and the bar became too loud and noisy to hear properly. The women invited me to visit them at their houses the following week so we could talk further. We arranged a date and they said they would make some stewed peanut leaves, coconut and crushed nuts (*nyangana*) which I had said was my favourite Mozambiquan food*" (extract from field diary 14.10.2012).

When most of these older women first arrived in Khaya'manzi, they didn't know anyone. Caring for their families took up all their time. However, since they have had to diversify their source of income, they met each other, and forged a strong network of friends who provided financial and emotional support to each other. Thus increasing their ability for resilience in response to the situations of structural violence that they encountered. As one older woman, Elise explained:

"I am better now, I have my friends, and we have a small income that comes in, which means that we can help the children [grandchildren*]… we live close to each other and we help each other…It is not like when I first got here and I knew nobody. Then it was very difficult…Too hard" (Elise, 40, Mozambique).*

These grandmothers migrated in order to provide assistance to their children. Later they often stayed in Khaya'manzi to care for seriously ill grandchildren if their children had died. Through these circumstances many of them made friends with other women who were in similar situations, identified opportunities for income generation and built lives for themselves in Khaya'manzi.

Many of the older women also provided help and care for others within the migrant community of Khaya'manzi. Dudu is a grandmother, who moved to the community from her home in Swaziland. She initially came to the area to care for her daughter, and ended up staying to look after her three grandchildren, who she had never previously met.. She subsequently began caring for five more vulnerable children, all aged between two and seven years. Dudu explained how she had no knowledge of the whereabouts of the children's fathers, but was aware that their mothers have passed away. She explained that when she arrived in Khaya'manzi, she cared for her own family, but realised there were a great many more children within the migrant community who were in need of care. When she realised she would not be able to return to Swaziland, she decided to do what she described as her duty to God, and care for as many of these children as possible, thus displaying remarkable resilience in the context of her own situation. Dudu often found herself without funds, and relied heavily on the support of the local Zion Christian Church, who donated clothing, blankets and provided food parcels to her on a regular basis. She also accepted that her commitment to care for these additional children meant that she would never be able to return to her home community, as she described:

"I can't help myself, so I need, now, to help others. I can't go home, I don't have the money and I will not have the money – now I definitely will not have the money, because I have so many children, and so rather than sitting here in this place, I need to help the people that need it. Those people are children. I am committed now, to dying in this place" (Dudu, 45, Swaziland).

Dudu is not alone in her commitment to caring for others. Nancy is another older woman, who came to the area from Mozambique. When she realised that her situation meant that she would have to stay in Khaya'manzi, rather than return home, she started helping young women in the community who were newly-arrived migrants. She

believed that in offering a gesture of friendship, helping them to find work and safe places to live, and acting as an informal mother-figure, she was helping to ensure that the next generation of migrant women were less likely to fall prey to the vulnerability that women like her daughter were subjected to:

"My daughter was raped when she first arrived here. She knew no one, and slept outside for her first night here. She was vulnerable and a man took advantage of that. I don't want other young girls to have that, so I go and meet the taxis that come through from the borders, and show the girls who are lost where to go. I sometimes let them sleep in my room, and then in the morning help them with accommodation and work" (Nancy, 60, Mozambique).

Many older women stayed in Khaya'manzi for longer than they had initially planned or ended up staying permanently. Some participants expressed the view that they had stayed too long in Khaya'manzi to ever be able to return home as they believed that their home situations would have changed, with particular regard to their personal relationships with their partners or husbands. As one participant explained:

"I have been away too long…you see, in Mozambique, you can't leave a man too long by himself. It is not good…I hear now from my other children at home that he has taken another wife. Now I have no place to go, I have no home. I have got to stay here in this place now". (Elise, 40, Mozambique).

Participants like Elise explained how as time progressed, their husbands often took on younger wives or girlfriends and as a consequence, they felt unable to return home even if they should later find themselves in a financial position to do so. A discussion with another participant who had also experienced these circumstances provided an example:

"A man needs a wife, I made the decision to come to Khaya'manzi for my daughter, and he was left without a wife. It meant that he took a new, younger wife and she now has children, so I have had my place taken away… Because of this I rather stay here, I do not want to go back to be a second wife" (Duma, 40, Zimbabwe).

Some of the older women felt negative about staying permanently, and others expressed mixed views. Rebecca, who moved to Khaya'manzi described feeling unhappy when she realized she would never return home:

"I wish for my home, I wish for the green coconut trees, and the sparkling ocean. If I had not had my children, I would still have this. One by one, they have moved away to this country. South Africa, land of opportunity? Land of sickness and death, and now… Now what? Now I have nothing. Now I too, I am stuck here in this godforsaken Gomorrah…. Here where there is prostitution, disease, alcoholism, drugs. So many drugs, young men who beat their girlfriends, young men who have hundreds of girlfriends at once. This place? It is not a society, not a community… These people, they are not knowing the meaning of community" (Rebecca, 60, Mozambique).

The reference to Gomorrah alludes to the biblical city of Gomorrah that was destroyed by God because of the depravity of its inhabitants (Eisen 2000). Rebecca described Khaya'manzi in this way, because of her own negative experiences in the community and what she considered to be the destructive behaviour of some individuals.

Rebecca expressed the view that the death of her daughter was caused by her migration to this community, and the structural violence that could be associated with being a migrant in Khaya'manzi. She felt that the power of the historically advantaged community of white people who she understood controlled the allocation of jobs, and that the power of individuals of wealth in this minority community contributed to the

exacerbation of disadvantage of migrants to the area. She also discussed how she believed the extreme poverty experienced by many of the men, women and children in the community had led to the development of a society that could be dangerous to live in. Rebecca believed that Khaya'manzi was an unsafe area for children to grow up in. She expressed the view that she would never have had children, and as a direct result, grandchildren, had she been aware that they would end up living in a place like Khaya'manzi.

Other women, however, felt more positive about their move to Khaya'manzi. Jabu was a participant who was happy with her new life in Khaya'manzi. She had good friends, and was part of a new community that she loved. She expressed the view:

"I was sad, yes, when I first came, but as I made friends and created a job for myself, things got better. Now I have good friends, an income and I have my grandchildren, so I am not unhappy that I will stay here forever…Yes, I sometimes miss home, but there are also things that I am glad to be away from" (Jabu, 45, Mozambique).

Yet some had mixed feelings about their migration to Khaya'manzi. Nancy, despite her new life and role in the migrant community of Khaya'manzi described in detail how she missed her home in Mozambique, and in particular found the socio-political context of South Africa difficult to come to terms with:

"I love my friends, my place. South Africa though, it is just the same like Mozambique, except there is less dancing, less music, less joy and less beauty. There is more sickness, more sadness and much more poverty. No happiness. Young people don't have a future here the way they do at home, in my country. There, you have the ocean, here you have laws and regulations and permits for fishing. There, you have plentiful green landscapes, coconut trees that grow on every square inch of land, and where you

have coconuts, you can survive. Here, there is desert, drought, water bills, few lakes. There, you can grow your own vegetables, even the government provides the space for the people to do that. Here, you have to own land, for that you need money. Or, you can apply, risk getting thrown off, and in the end it is only a square inch that you belong to. What is the point in that?

No, Mozambique is a country full of sunshine, colour and beauty. South Africa? South Africa to me is a dull colour, maybe one time it was a bright yellow, but today it has dulled to brown. There is no joy in this place, no happiness. Not even the white man who I see with all his money and his huge farms, they have no happiness in their soul, they are full of sadness, greed and the anger. Anger is in all South Africans. Tell me, how can a country be rebuilt on a foundation of anger?" (Nancy, 60, Mozambique).

Section Conclusion

Older women often followed their children to Khaya'manzi when they were asked to help. On arrival in the community, many of these older women were exposed to difficult situations and often found their children struggling financially and physically with ill health, and trying to cope with challenging situations of structural violence. However, many older women formed friendship groups for support and expressed agency through finding ways of earning an income to provide for their families, working and trading, on the whole, in the informal sector. They expressed agency within the constraints of the socio-economic structures in South Africa, and in order to cope with the negative situations that they found themselves in, they identified and acted on ways to help and support their children and grandchildren.

5.5 Conclusion

This chapter has addressed the research question: How do patterns of migration intersect with women's landscapes of fertility? Female migrants have been described in literature as "birds of a feather" (Morokvasic 1984) and empowered agents of the process of migration (Boyle and Halfacree 1999, Kofmann et al 2000, Pessar and Piper 2005, Mahler 2006). However, I have argued that migratory patterns in Khaya'manzi are more complex than the single phase empowered flow that this suggests, and intersect with landscapes of fertility.

Migration to Khaya'manzi, rather than being a simple process undertaken by empowered agents from economically active generations, is clearly feminised, and could be described as a dual-phase intergenerational process that is highly gendered. Migration is motivated by both push and pull factors for women of all generations. Younger women migrated to the area in order to search for employment, and build a new life, sometimes alone, sometimes with their male partners. In doing so they were motivated by a pull factor, which was the promise of a better life in South Africa, and a push factor, which was the poverty and inequality that contributed to the situations of structural violence that they experienced in their home communities. Often, the fertility preferences of these women were important factors in this new life, and having children was put on hold until they had migrated away from their home communities. However, these women often struggled to achieve their desired lifestyle in Khaya'manzi due to the socio-economic structure of the labour market and land tenure which shaped, the work opportunities available to them, their often undocumented status and low wages. As a result, many made risky lifestyle choices and often ended up alone, unwell and in need of help for themselves and their children, living within situations of structural violence and sometimes, great danger.

As a consequence of their experiences of the structural violence caused by their migration, many were unable to cope, yet did so by requesting help from their mothers

as a livelihood strategy. In many cases, these older women became migratory followers of their children, who left their homes and travelled, initially on a temporary basis to Khaya'manzi to care for their children and their grandchildren. In doing so they responded to the pull factor of their child asking for help, as well as push factors, which were mostly a lack of money and poverty in their home communities.

Thus, as a consequence of choices made previously to have children, these older women often ended up living in difficult situations of structural violence in Khaya'manzi, living within the same socio-economic and political structure that so affected the lives of their children. These older women often demonstrated great strength and forged new lives for themselves. They often made supportive friends with women from similar situations and created new roles for themselves within the community as informal traders and carers for others.

The intersection of women's landscapes of fertility with migration can, therefore, be described as complex and subject to change over time. Yet for many, the two are intrinsically linked. Within this context, landscapes of fertility are often influenced by sadness, disappointment, and difficulty as well as positive influences such as increased independence and autonomy and opportunity. Migrant women's landscapes of fertility with migration are shaped by structuralist and humanistic influences. Landscapes of fertility are shaped by structure in terms of the inequalities that women experience in their home communities; the migrant labour system; undocumented immigration status; access to institutional social welfare structures; the financial situation of migrant women; gendered relationships and work opportunities as well as their reliance on labour-related housing. These are structural inequalities. However, interpretation from a humanistic perspective identifies that within their experience of these inequalities, women demonstrated that whilst they were often highly vulnerable, they were also able

to cope with their situations through adoption of livelihood strategies in order to provide for the daily needs of themselves and their households.

The following chapter will explore the influence of the HIV pandemic in Khaya'manzi on women's landscapes of fertility.

Chapter 6: Women's Experiences of HIV Within the Changing Socio-Political Context of the Disease in South Africa

6.1 Introduction

This chapter addresses the research question: To what extent does the HIV pandemic in South Africa contribute to women's landscapes of fertility? The question is addressed using data drawn from ethnographic fieldwork including observations, field notes, interviews, a modified participatory mapping exercise with women and interviews with service providers from a clinic in Khaya'manzi. In exploring the complexities of women's landscapes of fertility, the first section of the chapter examines women's experiences of HIV and fertility within the changing socio-political context of the disease. The second section explores women's explanations of their ill health and the third section explores the intersection of HIV, fertility and caring for children.

When HIV was first recognized as a global public health problem, its impact on women was widely ignored. This is because HIV was at first understood to be a disease that only affected men (Fassin 2007). However, when it became evident that HIV and AIDS was becoming more prevalent in areas of particularly sub-Saharan Africa it became clear that women were affected too and that there were different patterns of transmission (ibid.). Despite this however, women were long excluded from interventions focusing on HIV and AIDS, to the extent that female sufferers have been described in that early period as "invisible women" (Farmer 1999:59). This gendered exclusion has resulted in women in sub-Saharan Africa being affected by situations of structural violence created by HIV. However, the experience of structural violence has varied between women of different generations, as political response to the pandemic has changed over time.

6.2 Women's Intergenerational Experiences of HIV Within the Changing Political Context of the Disease

In South Africa, women from different generations and backgrounds have had a vastly different experience of the HIV pandemic. Older and middle aged women from

Khaya'manzi spoke of negative experiences of the disease throughout President Mbeki's term of office (1999-2008), whilst younger women described their more recent experiences of HIV in the context of President Zuma's government (2009 to the present). Women who were migrants from other African countries also described their differing experiences of the disease, particularly in terms of access to treatment. Older, middle-aged and migrant women thus encountered situations of structural violence within their experience of the HIV pandemic, whereas younger women were less likely to.

During the 1990s, and early 2000s, HIV in South Africa became widespread, and was recognised as a major public health issue that was simultaneously characterised by government 'denialism' (Lengwe Kunda and Tomaselli 2012). The government's response to HIV at this time is discussed in detail in Section 2.2. This was, however, an inadequate top-down response to the pandemic that affected women's access to treatment and the quality of health services for HIV and related illnesses that they received. Children were also affected by the government's lack of targeted treatment programmes (Lengwe Kunda and Tomaselli 2012).

Older and middle aged women from Khaya'manzi spoke about their personal experiences of the disease during this period of time. In particular, women discussed difficulties they incurred when accessing medication for HIV, how children's sickness affected them and the changes they noticed in their community during this period.

Zodwa recalled when her youngest daughter was diagnosed HIV-positive. It was in the late 1990s, when primary healthcare workers had little knowledge about the disease, and access to medication was severely limited. She explained how in her experience, medication was only made available to men:

"I woke up to her screaming, and crying…she was standing up, then falling over like she was dizzy, and kept saying 'the house is upside down'. I wasn't sure what to do, I knew that the sickness was bad like this, but this was scary. I took her to the large clinic, and asked for help. They gave her panadol (paracetemol) *and told me to take her home. I looked around the corner and saw a line, thirty people at least, all men, and they were being given medicine in plastic bottles. That was the only medicine you receive in a plastic bottle, not a packet… the AIDS medicine. There was no woman there. Not one. I went back inside, and spoke to the sister, and she told me women don't have AIDS. I must take my daughter home." (Zodwa, 50, South Africa).*

Participants described how female family members were regularly turned away from treatment centres and clinics, whilst simultaneously observing men being given ART:

"We couldn't understand why they wouldn't give the medicine to the women, men would get the pills, but women wouldn't…I think there wasn't enough, and in our culture men are more important" (Thuli, 61, South Africa).

However, others described standing in long queues of both men and women at primary healthcare clinics, hoping to receive ART, either for themselves or their children, but being turned away and told there was none available. As one participant explained:

"I waited and waited, there was a queue of maybe 40 men, 20 women…we were all so sick, no one spoke… just sat on the ground in the queue…then I was told there was nothing left" (Thandiwe, 36, South Africa).

Participants described difficulties of this kind that they encountered when trying to gain access to medication for HIV. Perhaps most relevant to landscapes of fertility are the experiences of women who were unable to access post mother to child transmission

therapy (PMTCT) during pregnancy. One participant described her daughter's experience:

"My daughter only found out she was HIV positive when she got pregnant, she wanted to know whether the baby would catch it from her, people were talking about this drug called AZ something that stopped it, so she asked about it at the clinic. She was told she couldn't have it because there was no supply in Khaya'manzi, she was told just to eat well and take a chance" (Zanele, 60, South Africa).

Clinic staff clarified that at this time, pregnant women were tested for HIV as a matter of course, so clinic staff and midwives would have known when a pregnant patient was HIV positive:

"*We had to write the status of every pregnant woman on the card, this then slotted in the documents file at the end of the bed. This made sure that all healthcare workers could take the necessary precautions to protect themselves during delivery*" (Sister 2).

This may, however, have had ethical implications, in terms of patient confidentiality, as cards were exposed to other patients, as well as healthcare workers. One participant explained that her status was on her clinic card, which was stuck at the end of her bed when she gave birth, and described how this made her feel:

"It was there, a big red stamp that said 'positive'. Everyone could see, it was embarrassing and I was so ashamed" (Thandiwe, 36, South Africa).

Despite measures taken to ensure knowledge the HIV status of pregnant women, in Khaya'manzi, ostensibly perhaps because clinics were not always allocated supplies of these drugs, pregnant, HIV positive women were regularly denied access to PMTCT

therapy. In many cases, it was not explained to women why they were unable to access the medication. Women in this situation, however, knew that access to PMTCT would have, essentially prevented their child from contracting HIV during pregnancy and childbirth. One woman recalled her experience of this:

"I was on ART, and I asked for the other drug [PMTCT] when I was pregnant. They told me I couldn't have it, and said I must look after myself and my baby would be OK. I did, look after myself, and I had the baby at the clinic...When my daughter was eleven years old, she started getting these sores in her mouth, her face was swollen and her tummy was very sick. I knew it was HIV before I took her to the clinic, she is now on ART, but most of the time, she is very sick" (Zeba, 34, South Africa).

However, during this period, some clinics were provided with supplies of drugs for HIV, including PMTCT. Some women who visited clinics in other areas of the country whilst pregnant explained that they were given the opportunity to take PMTCT. However, one participant believed, the sister from a clinic in a neighbouring province who she saw throughout her pregnancy gave her incorrect instructions, so the therapy was useless and her son was born with HIV:

"She told me to take all the tablets at once, only after he was born, rather than before and after like you are meant to. It made me really sick, and they had to induce my birth…Of course it didn't work, my baby had already taken HIV inside me and he was HIV positive" (Star, 38, South Africa).

Others discussed how children who were affected by this restricted access to PMTCT were often diagnosed HIV positive later, yet not prescribed ART. This happened as late as 2008. Women expressed the view that this was because of misinformed staff at rural government clinics. One participant explained:

"I took my child to have an HIV test, she was positive. This was in 2008. I asked for ART, or some treatment for her, but the sister told me that children cannot take ART… I buried my child six months after" (Davey, 27, South Africa).

The actual incidence of these situations was verified by interviews with clinic staff, two of whom discussed at length, what they saw to be the failings of the healthcare system in the early years of the pandemic to address the needs of, particularly HIV positive women and children. As one senior clinic sister explained:

"Women were ignored, we were briefed incorrectly, and first of all told that a female presenting with symptoms of AIDS was suffering rather from flu, as 'women couldn't get AIDS'. Then came the controversy over the drugs, as you know the president wouldn't allow us to receive them, we had people coming in dying all over the place, ambulances wouldn't come and take an AIDS patient, so we had to say it was flu. We got some medication, later in the 90's, but it was poor quality, inconsistent. We ended up treating the men first, we were told it was protocol. I believe they thought the men would get better, and they make up the most of the labour, particularly in our area. At that stage, it was still believed that women didn't get AIDS, so we turned them all away. It got better later, I went to the AIDS conference in Durban, the famous one where Mandela pleaded with the government to help, I then went on a training course, and learned all about the medicine… the course was in Cape Town, there they had medicine, so I was taught well. We got PMTCT, but other nurses in the unit didn't understand what it was, so refused to prescribe it, I made sure to teach all my staff, but the more rural clinics didn't know. I wasn't working here then… I was in Durban. I know that there were many many women who were refused PMTCT. They also refused children ARVs…. Apparently children couldn't get AIDS either, despite the [clinic workers] seeing so many dying every day" (Sister 1).

Participants described how, during this period of time, when the political response to the HIV pandemic was so confused, they noticed changes in the atmosphere in their community. Zoddi, an older woman who had lived in Khaya'manzi all her life, observed that at the time: *"there were no smiles" (Zoddi, around 60, South Africa).*

People became progressively unwell, and lost hope for the future as there was little access to medication at this time, a positive HIV diagnosis was understood to be life limiting and would inevitably lead to premature mortality. As one participant recalled:

"You would see people too exhausted to walk further, just collapsed at the side of the road, men so thin that they could hardly stand…people would be so sick, everywhere… children vomiting… there was no help and there didn't seem to be a tomorrow for many people" (Zanele, 60, South Africa).

Women who experienced the HIV pandemic during this period of time often referred to the impact that children falling ill had on their community. Perhaps because of the limited access to ART and PMTCT medication, children were heavily affected by the pandemic in the early years, and many died prematurely, or became very unwell. This had an impact on adults in the community, particularly women. One participant explained how her community was affected by the sickness and death of children that was caused by HIV:

"Children are our future, and so many were getting sick. It was like there was no tomorrow for our culture, our people, our community. It was like everything was dying. Our future was dying… Everything was ending" (Thuli, 62, South Africa).

Zodwa, another participant expressed this view:

"Us old women, we are the mothers of our community…all our children were dying. The small ones were getting sick and passing on. This made us sad, we were praying, asking for guidance, but when no help came for many years, we began to worry and fear for our future" (Zodwa, around 50, South Africa).

The situation did, however, improve and younger women from Khaya'manzi described different experiences of the South African HIV pandemic. As discussed in Chapter 2.2, President Mbeki resigned in 2008 and with the change in government came a change in policy related to HIV. VCT was rolled out and access to ART has continued to steadily rise.

Younger women from Khaya'manzi discussed their experiences of the HIV pandemic. In particular, they spoke about HIV positive women having children with the help of PMTCT, the normalisation of HIV within their community and the impact of the disease on their children.

Thabsile is a woman in her thirties. She had three children and then found a new boyfriend. She wanted to have another child, but began feeling unwell when they started trying to have a baby. She was tested for HIV and received a positive diagnosis. Her partner was also found to be HIV positive. Thabsile found out that she was two months pregnant with twins shortly before I interviewed her and discussed at length her experience and feelings about her pregnancy and HIV status:

"I have talked to the clinic about PMTCT, and I am taking the first phase pills now, I will increase the dose later and will make sure I do take it… I am eating well, resting and if I feel even a bit ill I go to the clinic. I have been on antibiotics twice already, and had the cholera [preventative] medicine... If I do this then my twins will be OK and

born health, without HIV. I think if I look after myself, I will be fine too, when I am in labour, I will go to the clinic to have the babies, then I know they can be looked after if there is a problem" (Thabsile, 33, South Africa).

Thabsile felt comfortable being pregnant and having a baby despite her positive HIV status because she believed in the efficacy of the drugs available to her, and the expertise of the clinic staff. She did not feel that her status should limit her choices with regards to her fertility, as long as she was proactive in taking medicine that would prevent in-vitro transmission of the disease, and transmission during birth. She stated: *"for me, the medicine is there and will help. I will have two healthy babies".*

Thabsile was able to reduce the risk of her children contracting the disease from her, because of the availability of PMTCT, and the proactive role she took in promoting her own good health during her pregnancy to complement their impact. Another woman discussed her own use of the medication:

"I took the PMTCT when I got pregnant, it wasn't even something I was thinking about, I knew I could go and get the pills and the baby would be OK… Now, HIV positive women can have babies without worrying" (Sn'tile, 21, South Africa).

But not all women had this confidence in the continued availability of these drugs and their ability to prevent mother to child transmission of the disease. This was perhaps due to the previous experiences of older generations of women from their community. As one participant recalled:

"It has happened before, they brought in medicine, then when you were half way through the course they ran out, so it didn't work and made us sick… Who knows what

is in these pills anyway? This disease it is bad, very, very bad, it can take out even the strongest big man, what about a small baby?" (Davey, 27, South Africa).

Despite the widespread availability of PMTCT through primary health clinics, not all participants took advantage of the available medication. Sallie, did not take PMTCT because she kept forgetting her clinic appointments. She explained that with hindsight since her baby was born with health problems and limited life span, she wished she had made more an effort to remember her appointments, and be proactive about taking the treatment:

"I just forgot, then it was too late, I missed the pills, so in the end I gave up. My baby is sick now, so I should have done it, the pills are there, the clinics are there and they are giving us a good service I should have used it to make my child better" (Sallie, 26, South Africa).

Another participant, Thandi was aware of the availability of the drugs but did not visit the clinic during her pregnancy and her baby was delivered by a doula. She explained that from her perspective, it was easier and more appropriate to see a traditional healer than attend clinic appointments:

"I didn't want to [take PMTCT]. It was effort for me, I know the baby might have been born healthier, but for me, it wasn't necessary. I had a doula and had my baby at home, I took the herbs from the traditional healer (sangoma) and I am taking herbs now to get rid of my own HIV, baby has some too" (Thandi, 23, South Africa).

The availability of PMTCT in Khaya'manzi has meant that HIV positive women are now able to have healthy babies. Most participants expressed the view that HIV positive diagnoses should not prevent women from having children. However, some

were uncomfortable with this, and did not agree. Jilly is a woman in her forties, from Zimbabwe. She explained her perspective:

"I have seen so many of my friends die and leave their children behind, so many children die and leave my friends behind. It only takes two missed pills, and you are sick. When you are sick, you cannot look after your children, and if you die your children cannot look after themselves and are left alone. It is not fair, HIV is a problem, and HIV positive women should take responsibility for their health and not put their children at risk of poverty" (Jilly, 41, Zimbabwe).

A sister from the clinic near to Khaya'manzi discussed her perspective on the topic of the now widespread availability of PMTCT, and reiterated, to an extent the views expressed by Jilly. She used examples from her professional experience, and explained:

"For the most part, I think it is a good thing that PMTCT is widely available. But, it should only be given with counseling and support for the patient...In my job, I see too many women who have HIV, who are lax in taking their ART, and then they get pregnant. They expect that the PMTCT is going to be made available to them. They don't take responsibility, they come back six months later pregnant again, they forget to take their ART, don't look after themselves and their children are the ones that suffer. PMTCT has given HIV positive women the opportunity to have children, in this culture that is huge, but it just can't be used as it is now policies need to change and there needs to be behavioural interventions to support its use too" (Sister 2).

Widespread access to PMTCT is just one example of how younger women in Khaya'manzi have experienced better facilities for HIV than women from previous generations and how their experiences of childbearing increasingly considers HIV as a condition that is sometimes controllable and preventable in terms of their children and

even themselves It is part of the fertility landscape in rural South Africa at this time. One participant described how facilities for HIV testing, treatment and care were widely available in their community:

"We have clinics where you get tested, vans where you get tested, tents where you get tested. When you are positive you get given ART, multivitamins and antibiotics, community health workers help you if you are sick, churches help, schools and crèches help, NGOs help" (Davey, 27, South Africa).

Participants indicated that particularly, Khaya'manzi's two clinics provided valuable HIV-related resources for them. Appendix 7 is an example of a map drawn by Wendy, a 21-year-old woman who grew up in a town close to Khaya'manzi and moved to the area to attend high school. She was given a basic map of Khaya'manzi, and on it indicated places that meant something to her. We walked together round the community, and she explained the significance of the places she had identified. She described the kind of help and support the clinic provided for her, as an HIV positive woman:

"I needed help, I was very sick. I went here, and was so stressed about them telling me I was going to die, but they helped me… I got medicine, I go there every month for a health check, and I now feel OK…They helped me so much, I think it is an important place for women's health (izimpilo yamadomazane)" (Wendy, 21, South Africa).

A sister from this clinic provided an example of her daily routine. The majority of her patients were women from Khaya'manzi, who were affected by HIV. She explained that for her, a typical day consisted mostly of HIV testing, treatment and care:

"Clinic starts at eight, after prayers. I first see patients who want HIV tests, who have been referred to me from the voluntary counseling and testing (VCT) room – they would have seen the health worker there the previous day. This is so that they can wait whist the test results come in. So, I do the tests and take the details down in the files. They are sent to wait for the VCT test at the back [of the clinic]. Then, depending on the day, it is likely I will see pregnant women for tests, many of them receive PMTCT pills, and have health check ups. On other days, I will have a TB clinic, where the majority of patients are HIV positive, I give out the antibiotics and do the health checks, sometimes I refer patients who haven't taken their drugs properly to the TB centre at the hospital. We have a children's clinic on a Wednesday, again it is mostly about ARV complications, and I often have to give out antibiotics.

After the first two hours of clinic are finished, I process the HIV test results. The results take two hours to come in. I call each patient in, if they are positive, I prescribe ART, along with information about keeping healthy and a treatment plan which involves return visits to me. They are then sent back to VCT to make a series of appointments for support, the first of which will be the same day. If negative, they are counseled too, and sent away with a packet of free condoms and advice about keeping healthy.

In the afternoons, I have two hours of general clinic, which can send me patients with anything from cholera to a sore foot or a bullet or knife wound. I finish my day with rounds in the ward for expectant mothers. This is where we put women who are in labour, about to go into labour, who have experienced complications, or women who are HIV positive, and unwell, who need extra support during delivery. I test blood pressure, and do health checks, and of course, if there is a delivery – that's me too. HIV positive expectant mothers need lots of help and support during delivery, and labour, so that we can take every precaution there is to make sure their babies are not born HIV positive" (Sister 1).

Both women from Khaya'manzi and clinic staff described the extent to which HIV facilities and services were available to women in Khayamanzi. One participant, Zilly, a woman in her twenties, understood that the availability of these facilities, and the quality of care available has resulted in the disease becoming normal for people of her generation:

"Nowadays, HIV, it's ok, I go to the clinic, I get the pills, I get better. There is help for us. The clinics are helping us, they are hospitals for HIV… You are used to it now, most people have something like HIV, or someone with HIV" (Zilly, 25, South Africa).

Participants described how they felt HIV had been normalized in their community. This was apparent to Davey, who stated: *"HIV, its normal now" (Davey, 27, South Africa).*

Consequently, many younger women felt that the experience of being HIV positive had become less inhibiting for sufferers, and the disease was less visible to others. This resulted in a better quality of life for HIV positive women from their community. One woman expressed the view:

"There is good treatment, it means you can live a full life if you are HIV positive. People can't tell anymore if you are HIV positive. It means that people aren't horrible to HIV positive people anymore" (Beauty, 28, South Africa).

But not all participants felt that stigma related to HIV was completely eradicated from the community. Participants agreed that HIV positive adults were rarely affected. However, it was suggested that children affected by HIV were regularly teased and upset by their peers. This mostly happened at school, where children were taunted for

being weak, or having sick family members. One participant described an experience her child had at school:

*"Our family is like most here – there is some HIV. My boy was sick when he was small, but we had him tested and he is fine. He started school after crèche and the other kids would punch him, tease him and rip his uniform, they called him "sick kid" (*gulagane*) and told him he would die because his family were sick too" (Doma, 24, South Africa).*

Women also described how they felt that children with HIV positive mothers were often ignored, invisible or hidden *(bafihla)*. One participant observed that when a HIV-positive diagnosis of a woman was exposed to others in the community this often resulted in ostracism of the woman's children, rendering them invisible to their neighbours and previous friends. She understood that this ostracism later turned to bullying, and aggressive behaviour towards even the smallest of children when the mother's HIV progressed to AIDS, and physical symptoms were visible:

"I see these children are cruel, they see a mother struggle with the sickness, and they ignore the child, even if they were friends before, then as the mother gets worse the children hurt the other child, beat him and tease him too" (Davey, 27, South Africa).

However, most younger women tended to indicate that their experiences of HIV facilities and the attitudes of others were positive, particularly when compared to those had by previous generations. This was particularly evident in terms of access to facilities and treatment. Despite this, younger women who were migrants from other African countries tended to describe less positive experiences. Whilst migrant women were aware of facilities available for HIV related treatment and care, these women expressed reluctance to access them. Precious who is a migrant from Mozambique explained her perspective:

"The problem is the clinic is run by the government, I am afraid that if I don't speak the language, don't understand or the sister sees that I look different, they will call for me to get sent back to Mozambique, or I will get put in jail, or hurt by the police, because I am not meant to be here" (Precious, 22, Mozambique).

I interviewed the sisters who worked at the clinic, and requested clarification on the issues raised by these participants. One clarified this situation:

"In our constitution, it is about healthcare for all. They have no reason to be scared to come here I do not work for home affairs, I am not a policeman, I just help people get better. It doesn't interest me whether they are from Zimbabwe or England" (Sister 2).

As well as a reluctance to access state run medical facilities, some migrant women claimed that they had been refused access to them. One participant described an experience she had when she tried to attend an HIV voluntary counseling and testing (VCT) session and was refused entry to the clinic by the security guard:

"When I visited the clinic, I wanted the HIV test. The man at the gate spoke in Zulu and I didn't speak it properly. He chased me away, told me I wasn't allowed here…This is because he sees I am not South African" (Menehle, 18, Mozambique).

I explored this further with the sisters from the clinic, and one explained that it was an issue to do with limited supply of medication, and limited available appointments for services, rather than about the woman's migrant status as she had perceived:

"Sometimes, yes, people are turned away at the gate but this is not to do with being a migrant, it is everyone. It is because the clinic is full, there are no more spaces that day

for VCT, or there is no medication left and we are waiting for the pharmacy to deliver more… In this case she would have been told to come back the following day, early in the morning for VCT, or after a Thursday when the pharmacy has come by for medication. Maybe because she didn't understand Zulu, she didn't know what the guard was saying, it was not because she was a migrant" (Sister 1).

Some participants, like Menehle and Beauty expressed sadness and regret that their inability to access particularly PMTCT and ART had impacted negatively on their children. As one woman explained:

"I wasn't able to go to the clinic for the medicine when I was pregnant, so my child was born sick. I can't take my child to the clinic because I am scared they will send me away. I feel bad because my child is now suffering because of me" (Princesse, 24 Zimbabwe).

Some younger migrant women also indicated that they experienced stigmatization because of what they understood to be the visual manifestation of the HIV, when they felt unable to seek treatment for symptoms. As Thembeka described:

"The sicker I got, the less people spoke to me, greeted me. I had sores on my face, and was very thin, I wasn't taking medicine, so I was in bed for long time and hardly saw any other person" (Thembeka, 24, Zimbabwe).

However, other participants who experienced similar symptoms did not make this connection, and explained when asked that they felt they had received support from other members of the migrant community of Khaya'manzi. They indicated that any

negativity from South Africans was caused by xenophobic attitudes, and not HIV-related[10]. Tilly a migrant from Mozambique described her perspective:

"My neighbours helped me so much as I got sicker, we are all migrants so we do that. We women help each other… I don't think the attitude of South Africans changed to me, there is always a bad relationship between migrants and South Africans, I think it is because we are foreign. It is not about being HIV positive, they all are too, it is because we are migrants that they are nasty to us" (Tilly, 23, Mozambique).

Section Conclusion

The socio-political context of South Africa has had a strong influence on women's experiences of HIV. Older women who experienced the delayed political response and confusion to the pandemic described more negative experiences of HIV, and described the disease as a death sentence and life limiting. Younger women however, who experienced the disease since the widespread ARV rollout, discussed the normalization of HIV. Many of these younger women now interpret HIV as a chronic disease that can be easily treated, and does not limit life choices including having children because of available treatment and care. However, younger women who were migrants from other African countries, despite the change in political climate and government response to the disease, incurred obstacles that often prevented their access to treatment and care for HIV. Thus older and migrant women's interpretations of the HIV pandemic within their landscapes of fertility were framed within their experiences of structural violence.

[10] There has been a rise in Xenophobia in South Africa in recent years, which has manifested in terms of anti-migrant sentiment and violent clashes and protests between South African and migrant communities. A major cause of Xenophobia is the perception of South Africans that migrants are taking jobs away from them, thus exacerbating the problems caused by an already stretched local labour market (Barbarin and Richter 2013).

Women from different generations have experienced varying structural influences of the HIV pandemic on their landscapes of fertility. For older women, these were negative influences, created by Mbeki's political administration, and included: poor quality healthcare facilities and limited access to PMTCT and ART, which in turn exposed them and their children to situations of structural violence. For younger women, the influence of this disease on their landscapes of fertility were more positive and include the government's response to the disease, which can be associated with comprehensive healthcare services for HIV and related illnesses, and widespread access to medication and treatment.

From a humanistic perspective, the association of HIV with landscapes of fertility is about women's negotiation of these structural influences. Both older and migrant women had to cope with the negative situations created by their experience of the HIV pandemic, in order to survive. However, these women's experiences tended to affect their trust in public services, and in turn made some reluctant to access government healthcare services. Younger women, however, were able to access better quality health services that enabled them to manage their experiences of HIV and make choices about their fertility and pregnancies within the context of the disease in Khaya'manzi.

6.3 Explanatory Models of the Causation of HIV and AIDS

Women in Khaya'manzi tended to make sense of HIV and AIDS through explanatory models of causation that included some blame directed towards men, migrants, children and white employers (Kleinman 1976). Women discussed the patterns of gender relations, particularly the behaviour of men in black South African households,

perceived promiscuity of migrants and employment practices of white employers towards their black employees when they were sick. Their explanatory models were embedded within the structural violence present in South African society. This is shaped, historically, by the legacy of apartheid and the segmented unequal labour market that depended and still does to some extent on labour migration.

Women of all ages and backgrounds held men responsible for their experiences of HIV. Some women blamed the attitudes and actions of men generally for the spread and impact of the disease in Khaya'manzi, whereas other participants discussed the feelings of blame they held specifically towards previous sexual partners, husbands, and boyfriends.

Men were described as being routinely unfaithful to their partners and women associated this with the spread of HIV in the community. Davey explained her perspective on this:

"In this area, it is the men who cause the problems. The women, we just wanting a nice, small home in a safe place to bring up our children. The men, is one woman enough? Oh no…They say they only sleep with the sex workers with a condom and without with their wife, that is not true. It is the men who cause the disease to spread... Filthy, dirty men" (Davey, 27, South Africa).

Older women suggested that it was younger men in particular who displayed behaviour of this kind. As one participant expressed:

"There was no HIV when I was young. Men took new wives there was no sleeping around with a new partner every night like young men do now…It is something that the young ones do" (Thuli, 62, South Africa).

South African women tended to link the concept of male infidelity with migration and HIV in Khaya'manzi. Davey, whose previous boyfriend was from Mozambique explained her perspective:

"This behaviour, it is not right for our culture, it has come with the foreigners. The Mozambiquans, the Nigerians. It is because of this that there is this HIV in my community" (Davey, 27, South Africa).

Women originally from Khaya'manzi often blamed the spread of the disease in their community on the behaviour of migrants from other African countries. Participants felt that migrant women were promiscuous, and migrant men were irresponsible and had too many sexual partners. One participant expressed the view:

"Women from Mozambique sleep around all the time… The men are worse, they have too many girlfriends, don't know what a condom is… This is making the disease worse here" (Pretty, 28, South Africa).

However, women from all backgrounds agreed that abusive relationships were widespread through all sectors of the community. Participants understood that relationships of this kind resulted in the vulnerability of women, and increased their susceptibility to contracting HIV. Participants often described their own experiences in abusive relationships, and their observations of others within their community. Davey, described how she was abused by her boyfriend on a regular basis:

"He used to beat me, and I felt afraid, I didn't have any confidence, and he made me have sex with him when he wanted it… I was too shy to ask to use a condom, he would beat me again, but I knew he slept around so I was scared" (Davey, 27, South Africa).

The physical abuse that Davey endured meant that she lacked the confidence to insist on condom use during sex, and was vulnerable to HIV infection. Other women described their own similar experiences, and those they had observed. One woman described her feelings when she realised a neighbour was in an abusive relationship:

"I heard fights, and she came out with bruises, but I was more worried because I knew he slept with sex workers, and then would sleep with her, I used to talk to her, she had to keep safe, and protect herself against HIV" (Dinance, 30, Mozambique).

Participants expressed concern for others known to be in vulnerable situations, and anger and blame towards men who behaved in this way. As one participant expressed:

"It is sick, they treat their wives badly, then rape them, using condoms? No, men don't like to eat sweets with the wrappers on, in the meantime the women are the ones who suffer. It is the fault of men, men spread the disease" (Patience, 30, South Africa).

Sandile, a man in his twenties explained his perspective on the behaviour of men in the community, and how it relates to HIV. He explained:

*"Men here, yes, they do sleep around. It is something that is in our culture, nowadays we can't afford to have more wives, the brideprice (*lobola*) is more expensive, so we go somewhere else. But, the important thing to remember, we want to keep our wives safe, we use condoms with the sex workers, so we can keep our wives safe from HIV. That way it doesn't matter" (Sandile (27), boyfriend of Pumeli (19), South Africa).*

Men were blamed, not only for the effects of the pandemic on women, but for the impact it had on children. It was suggested that men were irresponsible towards their

families, particularly in terms of providing support and finance to assist with HIV care. One participant, Rebecca believed that children suffered the most from the pandemic, as they did not receive care, and men did not provide for them:

"There is no money, so they get sicker, there is no food so they can't get well. [The children] are exposed to terrible things, sickness, death, that no child should ever know. Not when they are that small. It damages them in the head" (Rebecca, 50, Mozambique).

Alongside the blame that some participants apportioned to men in general, others indicated that they blamed specific men for their own experience of HIV. These men were typically the previous sexual partners, boyfriends or husbands of the women concerned. Thando discussed her experience of HIV and AIDS. She explained that she felt anger towards her ex-husband, because she believed it was his behaviour that had resulted in her contraction of HIV. She blamed him for her poverty, which she knew was created by her illness:

"I hate him. I have so much anger about him. Him and his girlfriends, they caused my poverty, this bad life…I hate him... He is the lucky one because now he is dead (Thando, 28, South Africa).

Women who identified that they were HIV positive typically expressed anger towards their previous partners in this way. They also indicated that they felt anger towards their children and also blamed them for their experiences of the disease.

Thando explained that since the death of her husband from AIDS-related illness, she had transferred the anger she had felt towards him, to her son. Thando discussed how her situation degenerated as she entered the later phases of AIDS. Simultaneously, her

son grew up and began to behave more like a man rather than a boy. Thando began to associate him and his behaviour with that of his deceased father:

"I want to control my hurt, my anger…it just bubbles inside me all the time, I want to scream to hit him, to chase him. I hate him. I know he is my son, he is not though, he is my husband's son, he looks like him, he acts like him. All the time I am getting sicker. I blame him for my sickness, so I can never forget…I sometimes think I am getting better, but then I wake up in the morning and I am sick, then I remember that I hate him" (Thando, 28, South Africa).

Women often believed that the choice they made to have children was what caused them to become unwell in the first place. As such, some described feeling angry and blaming their children for their illness. As one woman explained:

"I wanted children all my life, so badly. I waited until I moved here to have them, and they made me sick. It is because of these two children that I am so ill… their fault" (Princess, 24, Zimbabwe).

Women who felt this way about their children often relied on their own mothers to care for them. Pansy was a single mother who explained that she felt such anger towards her two children that she couldn't stand to have them near her. As such, she sent them to be cared for by her mother, who lived in Trust, which is a village in another province in South Africa. She explained why:

"I can't look at them, I hate that they took away my life…I gave everything I had to make a life and have these children, but they took my life away… I sent them away then, to my mother" (Pansy, 26, South Africa).

Thombi is a grandmother, who looked after her grandchildren when her daughter became ill. Her daughter expressed similar feelings towards her children. Thombi explained how she sometimes felt frightened about her daughter's behaviour and attitude towards the children and couldn't understand it:

"She used to scream, like she was losing her mind at the little ones, she was crazy… I was scared and when she was there took the children away and try make them feel better… I don't understand why, she is sick, it is not their fault, I don't know why she blames them" (Thombi, 64, South Africa).

Women experienced feelings of anger and blamed other members of their own communities and families for their experiences of the HIV pandemic. In addition to this, some participants expressed negative feelings towards local White people for what was perceived to be their role in the impact of the HIV pandemic in Khaya'manzi. It was suggested that white people were not supportive or helpful to those affected by the disease:

"They just sit with all their money in their big houses and do nothing, even though we are living in their compounds" (Tilly, 23, Mozambique).

In particular, women believed that white people should provide work opportunities to people without discriminating against HIV status. This would ensure that families affected by the disease did not live in poverty. However, as one woman explained:

"Why should it make a difference if you employ someone with HIV or not? Everyone needs the money, otherwise they suffer, it is not like that. These white people as soon as they are thinking someone has HIV, they get rid of them, then what?" (Dinance, 30, Mozambique).

Some women claimed that they or their friends had been made redundant from work on local farms or in the nearby tourist town when it had become clear that they were not well, or had too many days off for clinic appointments. Prudence is one participant who explained how this made her feel:

"I hate it, it is not fair. [White people] can afford to help us but they don't. I lost my job when I was sick and was sometimes at the clinic, now I am hating them, they make people worse, and make people live in bad places, it is because of them" (Prudence, 40, Swaziland).

Jilly left Zimbabwe and travelled to Khaya'manzi in search of work opportunities. She also wanted to get away from the negative political situation in her home country. She found work as a cleaner at a restaurant in the nearby tourist town, which was and remains a town predominantly for white people. However, after a couple of years in the same job, she became unwell and had a substantial amount of time away from work whilst she started her antiretroviral medication and became used to the medication. She lost her job shortly after this period, because, she claims, the white owner realised she was HIV positive. Jilly explained how she now felt resentful against the restaurant owners, and blamed them for the exacerbation of her condition, which she felt was caused by poor nutrition, as, after she lost her job she was unable to afford to eat well to get better. She further discussed how she believed that many of her friend and neighbours in Khaya'manzi have been exposed to similar situations. She believes that when their HIV status became obvious to their employer, they were made redundant from their jobs. Jilly understands:

"This situation, here, in this place, it is made worse by the white men. They don't help, they just take away our wages when we need it most. It means that we can't afford to

live healthily, which when you have HIV you need to do. Then it means that people get sicker and sicker, they can't do anything, they just die" (Jilly, 41 Zimbabwe).

Thus, historically advantaged white people were understood to have taken jobs and income away from HIV positive women, which resulted in an exacerbation of the impact of the disease on black African communities, households and individuals. Participants indicated that in these situations, it was often the children of these women who were the most affected. As one participant expressed:

"Where are they going to get the money to feed their children, send them to school, buy them clothes? If they don't have money, they can't look after themselves, they get sicker because they can't buy food, then it is the children who are left to look after themselves" (Davey, South Africa).

Consequently, women tended to associate the actions of white employers with the gradual deterioration of health and increased poverty of many children they observed in their community. Women expressed their anger towards white people, because of their unwillingness to care:

"I don't understand. How can they stand by and watch the children get sick, live without food? We are living in their compounds, they see us, they know we are here but still they are not helping" (Rebecca, 60, Mozambique).

Alongside the understanding that through their actions, white people were in part responsible for the increased impact of the disease in Khaya'manzi, some women expressed the view that white people used HIV to control the black population. This perspective stems, perhaps from policy implemented during the Apartheid era in the country. As explained in Chapter 2, in the Apartheid era, many women experienced

medical procedures such as forced sterilization. These procedures were imposed by the state in an attempt to control black population expansion (May 2000). As such, some older participants expressed the view that HIV was a disease invented by white people and sent to Khaya'manzi to curb black population expansion in Khaya'manzi. Mbali is an older woman from the community. She recalled her experience of being sterilized when she was in her twenties, and related it to HIV:

"I went to the health centre to have a baby, it was a hard birth and I was sore. When I came out I saw I had a scar on my stomach, but thought it was about the birth…We were trying to have another child, and none came, I went back to the clinic and they told me I can't have children anymore that I had the operation. I was told it was better for me like that...A lot of women had it too, the white people didn't want the black people to have children anymore. Now they are doing the same thing but have sent this HIV so that we all die" (Mbali, 54, South Africa).

Participants like Mbali who remembered these policies aimed at population control expressed anger towards white people for what they understood to be another attempt at eradicating the black African people from the country. One woman suggested:

"White people made sure that we didn't get medicine because they want to control us, they don't want black people here, they want us all to die… It is all their fault… And then they see us getting sick they just leave us" (Laurencia, 40, South Africa).

Section Conclusion

Women from Khaya'manzi identified explanatory models for the cause of HIV in their households and community. These influenced landscapes of fertility and typically incorporated blame towards men, male attitudes and abusive or irresponsible behaviour

towards women; the behaviour of migrants and sometimes children and the choices they made to have children. Others felt that local white people had exacerbated the impact of the disease in Khaya'manzi. In order to rationalise their experiences women drew on these explanatory models of causation, which encompassed blame of others for their own HIV contraction. A structural interpretation of the influence of explanatory models for the cause of HIV on landscapes of fertility addresses socio-cultural norms structural violence intrinsic in South African society and the migrant labour system. From a humanistic perspective, these explanatory models helped them to cope with the affect of the HIV pandemic on themselves and their households, as well as their community.

6.4 Women, HIV and Care for their Children

Women who indicated that they were HIV positive discussed the arrangements they made for the care of their children as they themselves became progressively unwell. These participants suggested that as their disease progressed, they felt increasingly exhausted and unable to care for their children. They looked to their community for support and help for their children as they realised they were dying.

Women described how degeneration into bad health caused by their HIV positive status resulted in them losing energy, feeling exhausted, and that they were often unable to move or get out of bed. One participant, Princesse explained how this made her feel:

"I lost energy, day by day a little more went away…I felt so tired, I couldn't get up, I just felt like I was turning into a shadow" (Princesse, 24, Zimbabwe).

This gradual deterioration of health meant that women often lacked the energy to care for their children. Thembeka is a single mother, who started the progression from HIV

to AIDS shortly after her youngest daughter was born. She found that she was unable to produce milk and could not feed her:

"I tried and tried, and I just didn't have any milk, I was trying to feed her with the formula then, but I wasn't holding her right, I kept dropping her down" (Thembeka, 24, Zimbabwe).

In these circumstances, mothers often helped their daughters with their children. Many of these grandmothers described their reactions as they watched their daughters struggle with little energy, as they tried to care for their children. As one participant explained:

"It made me so heartsore, I wanted to help her, she found moving, breathing, eating so difficult, and then the poor small children were struggling too." (Duma, 40, Zimbabwe).

Women who found themselves unable to care for their children because of their poor health often believed that they had failed their children. Davey is one such example:

"I wanted my baby (Umntwana wami). I wanted this so much, because I wanted to have this opportunity to look after my baby by myself, without having to answer to a man. I wanted to have this independence and be a modern woman. I wanted this so badly, I knew that I was going to look after it so well, and be one of those nice moms. But then I got sick, I knew I had failed it, I got my diagnosis and found that I was HIV positive, and then I knew it was the end. This little child that I had spent so much energy and time loving was going to be left alone, I had totally failed as a mom and I can't cope with knowing that…I am just going to die, I am no use anymore to him" (Davey, 27, South Africa).

Importantly, women like Davey also felt that their illness meant they had not managed to fulfill their roles as mothers. Pumelele described her feelings, and how they were exacerbated by the attitude of other women from the community:

"The only thing I wanted was to be a mother, and this HIV stopped me from doing that… It made me so sick I couldn't care for my daughter… I felt sad but then I heard women talking about me, they were saying I was a bad mother, I was failing my daughter, this made me angry but I was too tired to be cross" (Pumelele, 30, South Africa).

In situations like that of Pumelele, where women found it difficult to care for their children because of the impact of their illness, they often turned to their community for help.

As Pumelele became progressively unwell, she safeguarded the future of her children by encouraging them to play with their friends and spend time outside of her home:

"I found out my status at Easter, two years ago…I was put on ART, but that time they didn't really explain too much for me. I took them, and felt worse, so I stopped taking them. At that time, all I was doing was thinking too much, I was thinking about my children, who is going to take care of them, where I am going, am I going to miss them too much, it was making me very heartsore. I couldn't stand for them to be close to me, I made them leave me alone, go and play outside, and make friends, good friends who are going to look after them when I die. I didn't want them anymore, I don't still. I know I am going to die, I don't want to have to see them, to wash their clothes and give them food, to do their school work with them. I make them go and sleep in other places, with their friends and other people, I can't see them…I don't want to have to feel so heart sore. I haven't bought them their clothes, or food, because then I have to see

them. Rather it is better, I live with this disease in me alone, and I die, and someone will make sure rather that they are OK. That way, I don't have the worry and the stress I had when I first found out. It is better this way". (Pumelele, 30, South Africa).

Pumelele died in May 2013 and after her death, a neighbour and friend who she had known all her life cared for her children.

Women like Pumelele who were HIV positive and needed help with their children's care often relied on the care provided to children by the local crèches as the following account from field notes illustrates.

"This morning I was at one of the crèches in Khaya'manzi. Children started to arrive at around seven o' clock, and I helped give them breakfast, which today was oatmeal porridge. A little later, two small children arrived together, without, it seemed, a parent or carer. They must have been aged about 2 and 3, and were holding hands, walking together down the road, then into the crèche. The children were dressed badly, in torn and dirty clothing, and they looked like they had bad ringworm on their skin and lice. They hadn't brought a bag, as many of the children do, which usually contains snacks and juice for the morning, and they had no shoes on. One of the children had obviously wet himself.

It was explained to me that their mother was a single parent: her partner had died a couple of years ago. She herself was taken ill, and it is speculated that she is in the later stages of AIDS. It appeared to neighbours that as soon as she became very unwell, she essentially abandoned her children, neglecting their welfare and leaving them to fend for themselves, as she no longer appears able to care about their wellbeing. The children are sometimes helped by neighbours, and given clothes and fed

by others, but for the most part, they are left alone. They play in the road, and they are always dirty.

I asked the women why they thought this was the case. One suggested that situations like this have quite common, and explained that to her, it appeared as though once a woman, particularly a single woman receives her HIV positive diagnosis, and becomes unwell, she seems to lose the will to live, and pull herself through. She distances herself from her children, almost as if to protect herself from the hurt and stress caused by worrying about their welfare that she can no longer support, and what will happen to them when the inevitable outcome occurs, and she dies". (Extract from field diary 02.01.2013).

This crèche was often called upon to help children in this situation. To manage this, they had a cupboard full of spare clothes and regularly provided extra meals to children. One carer for the children explained:

"It is our job to make sure that the children are looked after. We give them food, and make sure they are warm, we make sure they are well and if not we take them to the clinic. We make sure that they are safe…At this time, with this terrible disease in our lives, we women help each other and make sure our children are safe" (Tholaka, crèche worker, South Africa).

Section Conclusion

The experience of HIV-related terminal illness meant that women often struggled to care for their children. When these women realised that they were finding it difficult to cope with their children, they often turned to members of their community and community organizations for support and help. Women used these organisations and

their services in order to cope with their situations and to ensure the continued care of their children. These actions enabled the women and their households to deal with catastrophic illness, and have an influence on their landscapes of fertility.

6.5 Conclusion

This chapter has addressed the research question: To what extent does the HIV/AIDS pandemic in South Africa contribute to women's landscapes of fertility?

Women's landscapes of fertility have been shaped by the HIV/AIDS pandemic.

The changing political response to the HIV pandemic has influenced the landscapes of fertility of women of different generations in different ways as it has considerably differed over time. As a consequence, women from different generations have had different experiences of the pandemic within their landscapes of fertility. Thus the experiences of older women are synonymous with sickness and death of women and children, and are framed within their experiences of structural violence. Those of younger women are, however, are more positive, and are concerned with making informed choices about their health and having children in the context of the disease. Younger women's experiences of the intersection of landscapes of fertility with HIV include accessible healthcare and medication, and government services such as crèches and clinics that offer support and services to women from Khaya'manzi.

However, despite the differing experiences that women of different generations had of HIV, as caused by the changes in political response to the disease, all women described ways that they coped with the structural violence created by HIV/AIDS within their landscapes of fertility, and when faced with complex, difficult situations that this created. Women also identified explanatory models for the impact of the pandemic on

themselves, their households and their community, which incorporated blame of men, migrants, children and the white community for HIV risk and incidence Khaya'manzi. These explanatory models focused on gender relations, in particular, the behaviour of men and migrants. They also concerned having children, as well as the labour market. In particular, the attitudes of white employers towards black African employees when sick, and other aspects of structural violence relating to the social structure of South Africa. The creation of these explanatory models of causation enabled women to make sense of why they had the illness when confronted with situations of structural violence relating to HIV that affected themselves, their households and their community.

Younger women, particularly those that were HIV positive, were able negotiate pregnancy and childbirth in the context of HIV with help from the improved access to medication, particularly PMTCT that women from older generations were restricted from accessing. Some women also resorted to the use of livelihood strategies to help them cope with the impact of the disease on their children, and consequently expressed autonomy and agency in their negotiation of HIV through community and household care for children.

The next chapter is the final chapter of the thesis and is a conclusion and discussion of the contribution to knowledge made by this thesis.

Chapter 7: Conclusion

This chapter presents the conclusions of this thesis concerning women's landscapes of fertility. The first section of the chapter presents how the research questions have been addressed; the second section presents the theoretical and empirical original contribution to knowledge. The third section explores the strengths and limitations of the study, and the fourth section deals with any ethical concerns encountered. The final

section presents recommendations for policy and practice and further opportunities for research in this area.

7.1 How the Research Questions Were Addressed

This thesis has explored women's understandings and beliefs about their landscapes of fertility in a rural area of KwaZulu-Natal province, South Africa. The study concentrated predominantly on fertility preferences as one aspect of women's landscapes of fertility. Women's landscapes of fertility were then explored in relation to patterns of migration and the South African HIV/AIDS pandemic. Three research questions have been answered:

1. What are women's intergenerational understandings of landscapes of fertility within the changing socio-economic context of rural South Africa?
2. How do patterns of migration intersect with women's landscapes of fertility?
3. To what extent does the HIV/AIDS pandemic in South Africa contribute to women's landscapes of fertility?

The first research question "What are women's intergenerational understandings of landscapes of fertility within the changing socio-economic context of rural South Africa?" was addressed in Chapter Four. The chapter presented the understandings of women from different generations of their fertility preferences, choices and consequences. In particular, this chapter highlighted how women of different ages presented different perspectives on fertility.

Part A of the chapter provided an analysis of selected variables from the 1998 and 2003 South African demographic and health surveys (DHS) in order to give a quantifiable account of changes in women's fertility preferences between the two survey years. This

quantitative analysis of the surveys revealed that women's ideal number of children (which pertains to fertility preferences) reduced between the survey years of 1998 and 2003. This reported reduction in ideal number of children could be correlated with educational background and attainment, electricity and toilet facilities, and knowledge of family planning. These factors are important indicators of the socio-political change that South Africa experienced during and immediately after the transition to democracy in 1998, and subsequently had a structural influence on women's landscapes of fertility.

Part B of the chapter built on the quantitative findings through an exploration of women's perspectives and understandings of their fertility. I presented an analysis of qualitative interviews and ethnographic field notes from during the fieldwork period. The perspectives of women from different generations were discussed about the role of children in ensuring continuity; the changing influence of the patriarchal society on women's autonomy and how this has influenced women's landscapes of fertility; women's understandings of how external influences are impacting on the gendered division of care within the household, and finally, the role of children in women's livelihood strategies.

I established that fertility preferences are subject to change over time, and differ between women of different generations. Older women's landscapes of fertility were influenced by understandings of the importance of continuity of family and socio-cultural norms and customs. Concurrently, for younger women, fertility was about choice and experiencing increasing levels of autonomy, new opportunities and increased independence created by socio-cultural, economic and societal changes in rural South Africa. As a consequence, it can be suggested that women of different generations inhabit different landscapes of fertility that are shaped by different influences, some which are structuralist and others that are humanistic.

The structuralist influences on landscapes of fertility included time, modernity, socio-cultural norms, patriarchal societal structure, care and poverty. For older women, positive influences on their landscapes of fertility were black African socio-cultural norms and the patriarchal societal structure. However, these for younger women were negative influences that were constraining to them. Society was described as changing, particularly in terms of the decreasing influence of the patriarchy on younger women, and socio-culural norms. This in turn created changes to these influences on landscapes of fertility. Thus, from a humanistic perspective, younger women were able to express autonomy and independence in order to negotiate the structures previously strongly imposed by the patriarchal societal structure and the socio-cultural norms that constrained them. However, for older women, these changes in society meant that they became increasingly concerned for their future care and wellbeing as well as the future of their communities and households. Despite these differing experiences of landscapes of fertility, women from all generations experienced changes to their autonomy as individuals, which enhanced their own ability to cope with structures that had a negative influence on their landscapes of fertility, as well as the ability of their households to cope with adverse situations.

The second research question: "How do patterns of migration intersect with women's landscapes of fertility?" was addressed in Chapter Five. This chapter explored how women's understandings of their landscapes of fertility were linked with the process of migration.

The chapter identified how younger women located migration within their landscapes of fertility, and consequently, how this later affected their own mothers. The chapter examined women's lived experiences and accounts of the process of migration, younger women's experience of migrating to Khaya'manzi and older women's experiences of migration.

The chapter identified that migration was a component of younger women's landscapes of fertility and that their perspectives on their fertility changed according to their migratory status, from their anticipated migration through to their experiences of post-migration. Women from older generations were subsequently affected by the situations of disadvantage that younger women were experiencing and they in turn expressed agency by becoming migratory followers of their daughters. This movement is a extension of typical paradigms of migration, which deal with the simple, single phase feminisation of migration, as it addresses migration from an intergenerational perspective, and explores how women from different generations can be migratory followers, or leaders. This chapter highlighted how women from different generations experienced migration differently.

Thus, inequalities and structural violence had a structuralist influence on women's landscapes of fertility and its intersection with migration, through women's exposure to the socio-economic structure of the South African migrant labour market and land tenure, as well as migrant status and how this impacted on their access to social welfare structures in South Africa. From a humanistic perspective, younger women coped with situations of adversity in their request to their mothers for help. The older women who responded to these requests became migratory followers of their daughters. These older women later demonstrated strength in their ability to cope with their situations and their negotiation of structural constraints, through their ingenuity and use of livelihood strategies, as well as caring for others, informal sector trading and growing and selling vegetables. Thus, migration can be described as intrinsic to women's landscapes of fertility.

The third research question: "To what extent does the HIV/AIDS pandemic in South Africa contribute to women's landscapes of fertility?" was addressed in Chapter Six.

This chapter explored the role of HIV within women's landscapes of fertility and how HIV influenced women's perspectives on and decision-making about their fertility. The chapter presented women's experiences of HIV with regards to their fertility; women's explanations of their ill health and the intersection of HIV, fertility and caring for children.

The chapter highlighted how women from different generations experienced HIV in different ways. This was predominantly due to the socio-political context of the disease, and the subsequent change in health policy between governments in South Africa.

Older women presented their negative experiences of accessing care for HIV, as they were often unable to access proper treatment, due to the Mbeki government's failure to address the public health issues associated with the HIV pandemic. In contrast, younger women tended to understand HIV as a chronic disease, rather than the premature mortality it would have led to in the past. This is mostly due to the advances in HIV prevention and treatment and the widened access Voluntary Counseling and Testing since 2010. The changing political response to HIV had a structuralist influence on women's landscapes of fertility: older women experienced situations of structural violence pertaining to HIV, whereas younger women experienced structural influences that supported living with a chronic condition within their landscapes of fertility such as crèches, clinics, medical services, and accessible ART and PMTCT treatment. Consequently, the structural influence of HIV within women's landscapes of fertility is very different for older women as opposed to younger women. However, from a humanistic perspective, all women demonstrated that they were about to cope with the negative impact of the HIV pandemic on them as individuals, within their households, and also at institutional levels in order to negotiate the situations of structural violence created by the disease. In particular, women of all ages developed explanatory models

of causation of the disease, which helped them to cope with the situations they encountered.

7.2 Theoretical and Empirical Contribution: Landscapes of Fertility

This thesis has made a theoretical contribution to knowledge through its use of the landscapes framework and patterns of migration. The thesis has made an empirical contribution to knowledge through its exploration of qualitative understandings of fertility preferences using multiple methods.

Theoretical Contribution to Knowledge

This thesis makes an original contribution to knowledge through its use of the landscapes framework as prescribed by Cosgrove in order to extend understandings of fertility. Cosgrove was a scholar from the New School of Cultural Geography, who argued that landscapes should be used as a framework in order to explore the structuralist and humanistic ideas that are relevant to a topic of interest. In doing so, he advocated for a "fruitful collaboration between structuralist and humanistic scholars" so that valuable new knowledge could be generated (Cosgrove 1987:95).

This thesis adopted the landscapes framework as prescribed by Cosgrove, in conjunction with the concept of structural violence, in order to explain the structuralist elements of women's landscapes of fertility. These included: intergenerational experiences, modernity, socio-cultural norms of the patriarchal society in Khaya'manzi, care and poverty. Structural influences on landscapes of fertility relevant to migration were socio-economic inequalities, structural violence and the socio-economic structure of the South African migrant labour market that was related to migrant status and social welfare structures. Finally, structural influences on landscapes of fertility with regards

to HIV were the changing political response to HIV in South Africa, structural violence, crèches, welfare support systems, clinics and medical services as well as accessible ART and PMTCT for women.

The humanistic components of these landscapes were also identified through exploration of the concepts of agency, autonomy, women's behaviour and coping mechanisms within women's landscapes of fertility. Thus, the humanistic components of landscapes of fertility were agency and resilience, autonomy, coping, ingenuity and vulnerability of women, the use of livelihood strategies, caring, informal sector trading, growing vegetables, and explanatory models for HIV. These humanistic actions influenced women in their negotiation of the structural components of their landscapes of fertility.

Through its adoption of the landscapes framework as prescribed by Cosgrove, this research contributes to existing literature about landscapes as well as that about structural violence. This thesis was, therefore, about landscapes of fertility that are shaped by structural violence and influenced by the affirmative action that women take in order to negotiate these situations of negativity and often, danger and adversity, poverty and inequality that are caused by this structural violence. This ability to cope with adversity was displayed by participants at an individual, household and institutional level.

This thesis adopted the landscapes framework in conjunction with structural violence in order to understand the South African context of fertility and its intersection with HIV and migration. In addition to the theoretical contributions to knowledge detailed above, the findings of this thesis could also be located within literature about migration and living with HIV.

Contrary to previous research, which argued that on becoming ill with AIDS related symptoms, migratory individuals would return to their home communities with their children, in order to receive care, unwell individuals who were vulnerable due to their undocumented nature in their host, South African communities, would actually, be unable to return home, and so contacted their mothers for help. Through a combination of this call for help from their children who were mostly female, and various other push factors older women became migratory followers of their daughters, and moved away from their home communities. This finding could extend understandings of the feminisation of migration, which intersects migration with gender, which currently locate younger women as empowered agents of migration, but place older women in the home, as non-actors in the process. I argue that far from being confined to the home space, older women may express agency in becoming migratory followers of their daughters. These older women then display resilience when dealing with the situations of structural violence that they encounter, which are integral to international migration.

These findings, therefore, situate this thesis within the fields new cultural geography as well making a contribution to the fields of migration studies, gender studies, public health and medical anthropology.

Empirical Contribution to Knowledge

This thesis makes a unique empirical contribution to knowledge through its exploration of qualitative findings about fertility preferences in rural South Africa.

The findings of this thesis build on previous quantitative work that identified trends and patterns in the fertility preferences of women (Kodzi et al 2010a; Kodzi et al 2010b; Sennot and Yeatman 2012; Yeatman et al 2013). For the most part, previous studies that explored these trends and patterns were conducted using quantitative methods

involving analysis of demographic survey data. However, recent critique of scholarship of this kind has identified that knowledge about fertility preferences could be extended by incorporation of qualitative understandings on the topic. This thesis used a sequential exploratory research design to identify, first, any change in fertility preferences of women between two different years, and secondly explored these findings using qualitative research methods. Consequently, an understanding of the individual and external factors that influenced women's fertility preferences, and any change in these fertility preferences over time could be identified. The findings of this thesis identified women's attitudes within their own social-cultural context towards their fertility preferences, and explored the factors that influenced these preferences.

The thesis therefore provides a unique contribution to empirical knowledge in terms of studying women's fertility preferences through a qualitative lens. Thus, a different perspective on what has previously been a highly quantitative topic has been presented in this research project.

7.3 Strengths and Limitations of the Study

This study has presented an original contribution to knowledge through investigation of women's landscapes of fertility. A variety of rich data was obtained during the fieldwork period, and the appreciation of the post-modern influence of the African femininity perspective resulted in generation of an inclusive, comprehensive understanding of landscapes of fertility in the context of rural South Africa. However, the study inevitably has some limitations: the study concentrated predominantly on women's fertility preferences as one aspect of landscapes of fertility. However, better

incorporation of the direct perspectives of men, or men's landscapes of fertility and infertility of men and women could have facilitated further exploration of landscapes of fertility. In addition, the study design could have placed more centrality on the secondary analysis of quantitative data.

During the fieldwork process, a wide variety of rich qualitative data was collected. This was then used to address the research questions. I spent long periods of time in the field collecting this data, and developed a strong rapport with many of the study participants. Most participants were willing to discuss sensitive topics and often divulged personal information.

The thesis accepted the influence of post-modern theory through adoption of the African femininity perspective. This facilitated the development of an inclusive, and wide-ranging study of women's fertility preferences within its local context.
The African femininity perspective was thus adopted in the thesis as a gender lens that aimed to facilitate fully- inclusive, non-discriminatory, locally relevant findings. In rejecting the Western concept of feminism, and adopting the African femininity perspective, this thesis took into account local socio-cultural contexts and the influence of men, whether positive or negative, on participants' lives. Thus, this gender lens facilitated the study of landscapes of fertility in this thesis.

However, I Initially intended to focus purely on women's perspectives and experiences of their fertility preferences, choices and consequences, without any consideration of men, or their influence on women's lives. I perceived that women were often marginalized within the black South African socio-cultural context, and wished to provide a voice for their views on this topic.

I later became conscious of the African femininity standpoint, which discourages gender-blind research. Prominent scholars of African regional feminism advocate this perspective, and understand that gender-blind research can exacerbate women's marginalization and gender-based discrimination in Africa (Tamale 2008). In order to respect this standpoint, I undertook to include men in family and group interviews when they were present at the interview location. However, I did not actively seek male participants for the study. In doing so, I believed I could concentrate on women's perspectives without attracting criticism for being gender-blind. Moreover, the highly patriarchal nature of Khaya'manzi in combination with my position as a young, white, female researcher may have made it difficult to conduct successful interviews with men.

This was manifested during the fieldwork period as I conducted sixty-six interviews in total, only four of which included men. I also engaged in informal conversations with people whilst observing in community areas. Men were rarely present in these conversations.

Female participants, however, discussed their male counterparts at length. Claims were made about the male perspective on topics relevant to landscapes of fertility. Many of these were derogatory and I was rarely able to have them confirmed or refuted. Therefore, additional evidence pertaining to men's perspectives and experiences of topics related to landscapes of fertility may have been beneficial to this study. This could be achieved through extension of this study using a mixed gender fieldwork team, so as to better access male opinions and perspectives within the local socio-cultural context.

The use of quantitative data in this study should also be considered in this section about limitations.

When I designed this mixed methods study, I included secondary analysis of South African Demographic and Health Survey (SADHS) data from 1998 and 2003. However, this data did not relate to the study as well as I had anticipated, and had little relevance to the second and third findings chapters. Thus, less emphasis was placed on the quantitative element of the study than originally expected.

However, at the end of 2012, when I was half way through the fieldwork for this thesis, a quantitative study called the National Income Dynamics Study (NIDS) was completed. This dataset may have been more relevant to this thesis, as it contained modules that pertained to HIV status and migration status of respondents. Incorporating analysis of the NIDS could have provided additional, relevant quantitative evidence regarding women's landscapes of fertility in South Africa that may have facilitated a more balanced study in terms of quantitative and qualitative contributions. However, I was unable to use this data as it only became available for public use in mid 2014, around the time that I was completing the writing up of this thesis.

Finally, I could have further extended knowledge about women's landscapes of fertility through incorporation of perspectives on infertility as well as fertility preferences. Due to time and word limit constraints, and the focused nature of a PhD thesis, I was only able to concentrate on one of these two topics.

7.4 Ethical Concerns

This study was concerned with soliciting women's opinions on topics relevant to landscapes of fertility. Interviews involved discussion with black African women about their health and about other, potentially sensitive topics. This raised a number of ethical concerns, which were addressed using ethics protocols. Retaining the anonymity and confidentiality of participants was also of central concern to this study.

I obtained ethical approval for this study from HSSREC committee at the University of Warwick, and through the University of KwaZulu-Natal (UKZN) in South Africa. In order to secure these permissions, I was required to set up referral networks using local primary healthcare clinics for any women I believed to be suffering from undiagnosed sexual and reproductive health conditions; those who indicated they had been abused and any who seemed in need of psychological support.

It was equally important to safeguard the anonymity and confidentiality of participants. This was achieved by the use of pseudonyms in interview transcriptions and field notes. I was also deliberately vague about personal, professional and demographic details of participants. HIV was a central topic in this study, and in order to retain medical confidentiality, I never asked a participant to disclose their HIV status. Many did, however, by choice.

Whilst most participants understood the importance of anonymity and confidentiality, some found the concept hard to relate to. Migrant women in particular felt that others would help them when exposed to their stories and often wanted to be named in the thesis.

These ethical issues were discussed in further detail in chapter 3.

7.5 Recommendations in Relation to Policy and Practice and Further Opportunities for Research

This thesis has identified a gap in current demographic research about personal perspectives on key quantitative, demographic indicators. It has also built on previous research undertaken by the Institute of Migration in Southern Africa (IOM SA) about

migrant health vulnerabilities (IOM 2010) as well as identified further opportunities for research.

Demographic Indicators – The Role of Qualitative or Mixed Methods Approaches

Demographic indicators are important for forecasting the future trends of the population of a country or region. Currently, the dominant paradigm for understanding the demography of a region is a quantitative, biomedical approach (Kodzi et al 2010). However, this thesis provides evidence that qualitative understandings of indicators such as fertility preferences can contribute to knowledge in the field of demography.

Fertility preferences are one such demographic indicator. They can help to project future change in birth rates, and, in turn, forecast demographic shifts. It is important to predict any potential demographic shifts, as they can have an impact on the policy and service requirements of the future population of a region.

To date, quantitative methods have mainly been used to develop understandings of fertility preferences. Surveys like the DHS and NIDS tend to include a single question that pertains to participants' fertility preferences. This is usually "what is the participant's ideal number of children?" Participants respond with numerical values, which are then used to predict future birth rates in the region.

In order to provide a more inclusive, comprehensive understanding of these important demographic indicators, mixed, or multiple methods research designs could be more widely used to understand demographic indicators like fertility preferences. In particular, the study of demographic indicators could be better incorporated into the discipline of anthropological demography, which uses anthropological theory and research design to better understand "demographic phenomena in current and past

populations" (Bernardi 2007). Consequently, knowledge could be extended about the reasons people make choices that affect demographic change.

Using the Landscapes Framework to Understand Demographic Indicators

In this thesis, I have demonstrated that a landscapes framework can extend knowledge about qualitative perspectives on fertility preferences. These perspectives can be used to develop a wider understanding of participants' circumstances and experiences that influence their preferred ideal number of children. Findings of this kind can be used to better inform predictions of future birth rates. They can also help to develop comprehensive understandings of the reasons for demographic change in a region. As such, policy and public service provision can be better informed to address the needs of the future demographic profile of the region and where necessary, public services can be recommissioned to target these requirements.

I therefore recommend that quantitative study of fertility preferences and other demographic indicators be complemented by qualitative research. Doing so is likely to extend knowledge about the wider issues associated with demographic change. A landscapes framework is a particularly useful way of conceptualising the wider study of an issue. As a result, demographic forecasts and their associated policy decisions can be better informed and more relevant to beneficiary needs.

Migrant Health Vulnerabilities

The institute of Migration in Southern Africa (IOM SA) has conducted extensive research about the health vulnerabilities of migrants in the region. Specific to South Africa, Their findings relate to inadequacies in terms of migrants access to primary

healthcare facilities and the vulnerability of migrants to the contraction of infectious disease such as HIV and sexually transmitted diseases and TB (IOM 2010).

Research conducted by the IOM South Africa identified inadequate healthcare service provision for migrants in, particularly rural areas. It was alleged that primary healthcare clinics were found to regularly informally reject migrant access of their service. This is despite the constitution allowing migrants access to these services. Consequently, the IOM established that because of obstacles to access of primary healthcare services, migrants were more vulnerable to infectious disease contraction.

In addition, migrants were found to be disadvantaged in terms of their allocated housing and wages, which was perceived to have a knock on effect on health.

The findings from this thesis have extended this work done by the IOM, and presented further discussion about migrant health vulnerabilities in South Africa.

This thesis has through discussion with both migrants, and key informants at primary healthcare clinics identified that migrants are not necessarily disadvantaged in terms of access to healthcare services. There was perhaps a lack of understanding on the part of migrants, when it came to refusal of service access, which participants and key informants understood to be created by language differences. Migrants were not allowed access to health services because of problems with medication supply and this was not caused by their migrant status. However, this finding was not explored using non participant observation and is based on accounts from migrants and health workers.

Migrants may tend to be unaware of their constitutional right to primary healthcare services, and unwilling to access state funded services. As such they are often highly

vulnerable to infectious disease contraction, and exacerbation of conditions, as they do not have access to medication and care.

Building on the identified low quality housing provision and low wages migrants receive, as identified by the IOM, participants in this study described their use of risky livelihood strategies as a direct knock on effect of these inadequate circumstances. This again, meant that migrants had more health vulnerabilities than other participants.

I therefore recommend that migrant focused interventions assist with informing migrant women about the services available for them to access in their area. In addition, programmes and interventions that target vulnerable migrant women to reduce their risk of contracting HIV through livelihood strategies to cope with difficult living conditions and circumstances.

Further Opportunities for Research

Further research could be conducted in order to advance the study of women's landscapes of fertility through investigation of the study of health-seeking behaviour in terms of women's fertility; understandings of men's perspectives on fertility and study of infertility. This could be achieved through postdoctoral research, academic publication or an additional, small-scale research project.

I was unable to use some of the data that I collected during the fieldwork period. This was because of the constraints imposed by the word limit of the thesis. Consequently, data about the health seeking behaviour of women in the context of their fertility was excluded. Analysis and publication of this data could extend knowledge about women's attitudes towards their health and health seeking behaviour in relation to their attitude towards their fertility, fertility preferences and even infertility.

Whilst this thesis did not incorporate the perspectives of men within the development of landscapes of fertility, study of their perspectives could extend knowledge about men's attitudes towards women, and how men's attitudes influence women's fertility preferences. This could be achieved through study of masculinities and fertility preferences in rural South Africa.

Finally, future research could deal with the concept of infertility within the topic of landscapes of fertility. Thus, the landscapes of fertility as identified in this thesis could be extended further to provide a more comprehensive understanding of all the different structuralist and humanistic components that are of relevance to the study of fertility.

This thesis has, therefore, demonstrated that both structuralist and humanistic factors influence women's landscapes of fertility in rural South Africa. Structuralist influences on landscapes of fertility are informed by the structural violence that is experienced by black African women from all generations, and backgrounds, in its different forms. Concurrently, humanistic aspects of the landscape are informed by the agency and resilience as an expression of agency that is demonstrated by these women in their negotiation of these impeding structures.

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Appendix 1: Demographic Details of Participants Involved in Interviews; Interview Type Also Showing Participation in Modified Participatory Mapping Exercise

Interview #	Pseudonym of participant	Date	Age of participant(s)	Where participant comes from	Village of residence	Kind of interview	Length of interview	Location of interview	Modified community mapping participant?
1	Nobuhle, Nomzamo	10.10.12	16, 16	Hluhluwe, South Africa; Swaziland	School hostel	Peer group	3h 40 min	Community Project School hostel (private room)	
2	Nobuhle	14.10.12	16	Hluhluwe, South Africa	School hostel	Individual follow up interview	2 hours	Community Project School hostel (private room)	Yes
3	Nomzamo	15.10.12	16	Swaziland	School hostel	Individual follow up interview	2 hours 20 min	Community Project School hostel (private room)	
4	Nomzamo; Thabsile	10.11.12	16, 33	Swaziland; Swaziland	School hostel, village C	Family (mother and daughter)	6 hours	Thabsile's house in Village A	
5	Jabu	22.10.12	42	Mozambique	Village D	Individual	4 hours	Jabu's house in Village D	Yes
6	Dudu; Elise	23.10.12	45, 40	Swaziland, Mozambique	Village D	Peer Group (2 participants)	3 hours	Community Project church office	
7	Dudu	14.10.12	45	Swaziland	Village B	Individual follow up interview	3 hours 25 minutes	Dudu's room in shared house, Village B	
8	Elise	29.10.12	46	Mozambique	Village B	Individual follow up interview	5 hours 10 minutes	Elise's room in shared house, Village B	
9	Beauty	5.11.12	25	Hluhluwe, South Africa	Village A	Individual	2 hours 1 hour 45 minutes	Community Project church office	
10	Pretty	5.11.12	28	Jozini, South Africa	Village A	Individual	2 hours	Community Project church office	
11	Sn'tile	6.11.12	21	Jozini, South Africa	Village B	Individual	1 hour 30 minutes	Sn'tile's room in staff accommodation, Village B	
12	Precious	16.11.12	22	Mozambique	Village B	Individual	1h 30 min	Precious's rented room in Village B	
13	Patience	16.11.12	30	Jozini, South Africa	Village C	Individual	1 h	Patience's house in Village C	
14	Thobile	19.11.12	27	Khaya'Manzi	Village A	Individual	4 hours	Thobile's house in Village C	
15	Menehle	20.11.12	18	Khaya'Manzi	Village A	Individual	3 hours	Village C crèche	Yes

16	Zodwa	22.11.12	50+-	Trust, South Africa	Village C	Individual	3 hours	Village C crèche	
17	Precious; Patience; Thobile	26.11.12	22 30 27	Mozambique; Jozini, South Africa; Khaya'manzi	Village C	Peer Group	2 hours	Village C crèche	
18	Menehle; Thobile	28.11.12	18 27	Mozambique, Khaya'Manzi	Village C	Peer Group	1 hour	Village C crèche	
19	Thobile and family, inc. 2 men	28.11.12	27, 35, 40 (male), 45 (male), 55	Khaya'manzi (father and mother originally from Swaziland)	Village C	Family group	5 hours	House in Village C	
20	Menehle and family including one man	29.11.12	18, 16, 22, 23, 40, 41 (male)	Mozambique	Village D	Family group	4 hours	House in Village D	
21	Thuli	30.11.12	62	Kwa M'Sane, South Africa	Local town (not village area)	Individual	1 h 30 mins	Thuli's house in town close to Khaya'Manzi	
22	Thuli; Zanele; Zoddi	30.11.12	62, 60, not sure (60 +-)	Kwa M'Sane, South Africa; Khaya'manzi' Mtubatuba, South Africa	Local town (not village area)	Peer Group	2 hours	Thuli's house in town close to Khaya'manzi	
23	Nelly	1.12.12	45	Mozambique	Village D	Individual	3 hours	Village D	Yes
24	Dinance; Zinhle; Zoddi	1.12.12	40, 22, 30	Swaziland, Swaziland, Mozambique	Village D	Peer Group	3 hours 30 min	Village D	
25	Dinance and family, including two men	3.12.12	30, 16, 15, 25 (male), 55, 60 (male)	Mozambique	Village D	Family group	4 h 30 min	Village D	
26	Zinhle and family	3.12.12	22, 30, 35	Swaziland	Village D	Family group	1 hour	Village D	
27	Gogo and family	11.12.12	60, 45, 20, 16	Khaya'manzi	Village C	Family group	5 hours	Village C	
28	Mbali and family, including two men	12.12.12	54, 60 (male) 18, 25, 30, 40 (male)	Khaya'manzi	Village C	Family group	3 hours	Village C	
29	Pumeli and family	19.12.12	19, 25, 30, 50	Khaya'manzi	Village C	Family group	6 hours (also stayed for long lunch with family)	Village C	
30	Gogo	21.12.2012	60	Khaya'manzi	Village C	Individual (return)	4h25m	Home in Village C	
31	Mbali	22.12.2012	54	Khaya'manzi	Village C	Individual (return)	3h15m	Home in Village C	
32	Pumeli	22.12.2012	19	Khaya'manzi	Village C	Individual (return)	3h	Home in Village C	
33	Nomzamo	14.1.13	16	Swaziland	School hostel	Individual (return)	5h	Community Project school hostel	
34	Jabu	16.1.13	42	Mozambique	Village C	Individual (return)	3h35m	Home in village C	
35	Elise	17.1.13	46	Mozambique	Village D	Individual (return)	6h	Room in shared house, village D	
36	Zodwa	30.1.13	50+-	Trust, South Africa	Village C	Individual (return)	3h	Home in village C	

37	Doma	4.2.13	24	Midlands, South Africa	Village D	Individual	3h	Home in village D	
38	Davey	5.2.13	27	Khaya'manzi	Village C	Individual	5h40	Village C creche	
39	Nancy	18.2.2013	60	Mozambique	Village D	Individual	4h30	Room in shared house, village D	
40	Rebecca	21.2.2013	50	Mozambique	Village D	Individual	6h	Room in shared house, village D	
41	Vanessa	22.2.2013	72	Mozambique	Village D	Individual	3h20	Room in shared house, village D	
42	Gogo and family	26.2.2013	60 20 20	Village C	Village C	Family group (return)	3h	Home in village C	
43	Davey	4.3.2013	27	Khaya'manzi	Village C	Individual (return)	1h30	Village C creche	
44	Jabu	4.3.2013	42	Mozambique	Village C	Individual (return)	3h	Home in village C	
45	Pretty	10.3.2013	28	Jozini, South Africa	Village A	Individual (return)	2h20	Community Project creche office	
46	Zodwa	11.3.2013	50+	Trust, South Africa	Village C	Individual (return)	1h30	Home in village C	
47	Rebecca	15.3.2013	60	Mozambique	Village D	Individual (return)	3h20	Village D	
48	Thembeka	15.3.2013	24	Zimbabwe	Village D	Individual	4h00	Village D	
49	Sallie	16.3.2013	26	Free State, South Africa	Village D	Individual	3h45	Room in village D	
50	Princesse	16.3.2013	24	Zimbabwe	Village D	Individual	3h00	Room in village D	
51	Princesse and mother, Duma	19.3.2013	24, 40	Zimbabwe	Village D	Family (mother and daughter)	6h00	Room in village D	
52	Pumelele	20.3.2013	30	South Africa	Village D	Individual	3h00	Room in village D	
D	Abi	22.3.2013	21	Khaya'manzia	Village C	Individual	1h30	Room in village C	
54	Thandi	22.3.2013	23	Mtubatuba, South Africa	Village C	Individual	2h00	Room in village C	
55	Thando Juju Zilly	24.3.2013	28 26 25	Jozini, South Africa Swaziland South Africa	Village A Village D Village B	Peer group	3h00	Outside general store	
56	Jilly; Laurencia	24.3.2013	41 40	Zimbabwe; South Africa	Village D	Peer group	2h30	Room in village D	
57	Wendy	24.3.2013	21	Mtubatuba South Africa	Village D	Individual	1h00	Room in village D	
58	Holli Siba	25.3.2013	32 Around 85	Mtubatuba South Africa	Village C	Peer group	1h45	Room in village C	
59	Ellie	27.3.2013	Around 70	Mtubatuba, South Africa	Village C	Individual	2h00	Room in village C	
60	Pansy	29.3.2013	26	Mozambique	Village D	Individual	1h00	Room in village D	

61	Thombi; Willow	29.3.2013	64 60	Mtubatuba, South Africa	Village C	Peer group	4h00	Room in village C	
62	Tilly	1.4.2013	23	Mozambique	Village D	Indiviudual	2h00	Room in village D	
63	Ember	1.4.2013	55	Zimbabwe	Village C	Individual	3h00	Village C	
64	Thandiwe	2.4.2013	36	Mtubatuba, South Africa	Village C	Individual	1h30	Village C	
65	Zeba	2.4.2013	34	Mtubatuba, South Africa	Village C	Individual	1h00	Room in village C	
66	Star	2.4.2013	38	East London, Eastern Cape	Village C	Individual	2h00	Village C	

Appendix 2: Ethics Approval Letters from HSSREC, University of Warwick, UK and HSSREC UKZN, South Africa

HSSREC University of Warwick

THE UNIVERSITY OF
WARWICK

Humanities and Social Sciences
Research Ethics Committee
Kirby Corner Road
Coventry
CV4 8UW

Ref: HSSREC/RP/bj1/ HSSREC: 45/11-12
06 June 2012 re-sent

Professor Gillian Hundt / Student - Alexandra Plowright
Applicant Maria Stuttaford
School of Health and Social Studies,
University of Warwick

Dear Professor Hundt / Ms Plowright

Ethical Application Reference: **45/11-12**
Info-Ed Reference: **33114**

RE: Women's health in KwaZulu Natal

Thank you for submitting your project to the Humanities and Social Sciences Research Ethics Sub-Committee for Chair's approval.

We are pleased to advise you that, under the authority delegated to us by the University of Warwick Research Ethics Committee, full approval for your project is hereby granted for a further period of 1 year effective from the date of this letter.

The only tiny suggestion the Chair suggests relates to the information sheet for interviewees – under the heading 'What is this PhD proposal about' it might be better to say '(grand)children or (grand)parents' rather than grandchildren or parents.

Any material changes to any aspect of the project will require further consideration by the Committee and the PI is required to notify the Committee as early as possible should they wish to make any such changes.

May I take this opportunity to wish you the very best of luck with this study.

Professor Rebecca Probert,

p/p. R. Probert

Chair of HSSREC

UNIVERSITY OF KWAZULU-NATAL
INYUVESI YAKWAZULU-NATALI

03 August 2012

Ms Alexandra S Plowright (1055087)
Africa Centre for Health and Population Studies

Dear Ms Plowright

PROTOCOL REFERENCE NUMBER: HSS/0562/012D
PROJECT TITLE: Fertility preferences in rural South Africa: Context, Landscapes and Structural Violence

In response to your application dated 26 June 2012, the Humanities & Social Sciences Research Ethics Committee has considered the abovementioned application and the protocol has been granted **FULL APPROVAL.**

Any alteration/s to the approved research protocol i.e. Questionnaire/Interview Schedule, Informed Consent Form, Title of the Project, Location of the Study, Research Approach and Methods must be reviewed and approved through the amendment /modification prior to its implementation. In case you have further queries, please quote the above reference number.
PLEASE NOTE: Research data should be securely stored in the school/department for a period of 5 years.

I take this opportunity of wishing you everything of the best with your study.

Yours faithfully

.....
Professor Steven Collings (Chair)
/ms

cc. Professor Gillian Hundt, Dr Maria Stuttaford and Professor Marie-Louise Newell
cc. Mrs S Grobler

Professor S Collings (Chair)
Humanities & Social Sc Research Ethics Committee
Westville Campus, Govan Mbheki Building
Postal Address: Private Bag X54001, Durban, 4000, South Africa
Telephone: +27 (0)31 260 3587/8350 **Facsimile:** +27 (0)31 260 4609 **Email:** ximbap@ukzn.ac.za / snymanm@ukzn.ac.za

HSSREC UKZN Renewal

UNIVERSITY OF KWAZULU-NATAL
INYUVESI YAKWAZULU-NATALI

28 June 2013

Ms Alexandra S Plowright (1055087)
Africa Centre for Health and Population Studies

Dear Ms Plowright

Protocol reference number: HSS/0562/012D
Project title: Fertility preferences in rural South Africa: Context, landscapes and Structural Violence

RECERTIFICATION APPROVAL

This letter confirms that you have been granted Recertification Approval for a period of one year from the date of this letter: This approval is based strictly on the research protocol submitted in 2012.

Any alteration s to the approved research protocol i.e. Questionnaire/Interview Schedule, Informed Consent Form, Title of the Project, Location of the Study must be reviewed and approved through the amendment /modification prior to its implementation. Please quote the above reference number for all queries relating to this study. PLEASE NOTE: Research data should be securely stored in the school/department for a period of 5 years

Yours faithfully

.....
Dr Shenuka Singh (Deputy Chair)
Humanities & Social Science Research Ethics Committee

cc Professor Gillian Hundit, Dr Maria Stuttaford and Professor Marie-Louise Newell
cc Mrs S Grobler

Humanities & Social Sciences Research Ethics Committee
Professor Urmilla Bob (Chair) and Dr Shenuka Singh (Deputy Chair)
Westville Campus, Govan Mbeki Building
Postal Address: Private Bag X54001, Durban, 4000, South Africa
Telephone: +27 (0)31 260 3587/8350/4557 **Facsimile:** +27 (0)31 260 4609 **Email:** ximbap@ukzn.ac.za / snymanm@ukzn.ac.za / mohunp@ukn.ac.za
Website: www.ukzn.ac.za
Founding Campuses: Edgewood Howard College Medical School Pietermaritzburg Westville

Poster

THE UNIVERSITY OF WARWICK

Women's health in KwaZulu-Natal

I am a student from the UK, currently studying for my PhD degree at the University of Warwick. I would like to visit your organization to observe what happens there.

What is project about?

I am interested in finding out about the choices Zulu men and women make and their experiences of having children.

Why is this organization being asked to take part?

I would like this organisation to help me because I am interested in observing what happens there on a daily basis and finding out more about isiZulu culture.

What happens when the researcher visits the centre?

I would like to observe what happens at the centre on a daily basis. I would also like to briefly talk to staff members, and visitors so that things that I may not fully understand can be explained to me. Any conversations will be in isiZulu. I may also want to ask some adult, female staff members or visitors to take part in interviews at a later stage.

Do you have any questions you would like to ask me?

You can contact me on:

Alexandra Plowright
0788836056
A.S.Plowright@Warwick.ac.uk

IMPILO YABESIMAME KWAZULU NATAL

Ngingumfundi osuka e-UK, oqeqeshela izifundo ze PhD degree enyuvesi yase Warwick. Ngifisa ukuvakashela inhlangano yenu ukuze ngithole ukuthi nisebenza kanjani.

LUMAYELANA NANI LOLUHLAZIYO ?

Ngizothanda ukuthola kabanzi mayelana nezindlela ezahlukene abantu besimame nabesilisa abahlangabezana nazo ekubeni abantwana.

KUNGANI LENHLANGANO ICELWE UKUBA IBAMBE IQHAZA ?

Ngizofisa lenhlangano ukuba ingilekelele ngoba ngithanda ukubheka ukuthi kwenzakalani lapho zinsuku zonke, futhi nokuthola kabanzi ngamasiko esiZulu.

KWENZAKALANI UMA UMCWANINGI EVAKASHELA ISIKHUNGO ?

Ngizofisa ukubona ukuthi kwenzakalani esikhungweni zinsuku zonke. Ngizothanda futhi ukuthi ngikhulume nabasebenzi kanye nezivakashi, ukuze izinto engingaziqondi ngithole ukuchazeleka ngazo. Noma iziphi izinkulumo zizobe zingesiZulu. Ngingaphinde ngicele futhi abasebenzi abakhulile besimame kanye nabavakashi ukuba bebambe iqhaza ekuphenduleni imibuzo esikhathini esizayo.

Ngabe unayo imibuzo ongafisa ukungibuza yona ?

Ungaxhumana nami ku:

Alexandra Plowright
078 883 6056
A.S.Plowright@Warwick.ac.uk

THE UNIVERSITY OF WARWICK

Information Sheet: Observation within organisations

Women's health in KwaZulu-Natal

My name is Alex Plowright and I live in Monzi, near Mtubatuba. I am currently studying for a PhD degree with the University of Warwick in the UK and am based at the Africa Centre whilst doing this research. I am asking you to help me by allowing me to come to your place of work and observe what happens there and maybe talk to some of the people who I see there.

Before you agree to help me, it is important that I explain to you why I want to do this.

Please read the rest of this information sheet carefully, and then if you want to ask any questions, or need any more information before you sign the form please feel free to ask me.

What is this project about?

I am interested in finding out about the choices Zulu men and women make and their experiences of having children.

Why am I being asked to take part?

I would like you to help me with this because your place of work is very interesting and there are a lot of people who work there and visit there every day.

What will happen if I agree to take part?

I would like to come and visit your place of work, and observe what happens there in order to find out more about the isiZulu culture. I would also like to talk briefly to women who work there about some of the things that I see, so I can fully understand. I would also like to recruit some women from to take part in interviews.

I would like to be able to come to visit regularly between April and December 2012, for a full day at least once every two weeks.

If you agree to take part in this research, you are required to sign the informed consent form on the next page on behalf of your organisation.

Is it confidential?

Confidentiality and Anonymity will apply to anything you say. That means that the names of all organisations and people who work for them will be kept secret and anything I observe will not be attributed to your organisation in a way that identifies it,

School of Health and Social Studies

The University of Warwick
Coventry CV4 7AL United Kingdom
Tel: +44 (0)24 76574136
Email: a.s.plowright@warwick.ac.uk

or any members of staff. Neither you nor anyone from or associated with your organisation will be asked to tell me your health statuses or anything you do not want to say.

Where will data be kept?

Any notes I have made will be kept for ten years safely in a password-protected computer and any papers that have been signed, or that personal details are written on will be kept locked in a secure place. I am the only person who will know where these are. I may use data from my observations in future publications, however any quotes used will be anonymous.

What if I do not want to participate anymore?

It is entirely your choice whether or not you agree to help me by allowing me to come and spend time at your place of work, and if you wish to withdraw at any time, you can do so without penalization or disadvantage.

Who do I contact if I have any complaints about this research?

If you have any complaints at any stage of this research please do not hesitate to contact me, my university supervisor, Professor Gillian Hundt Gillian.Hundt@Warwick.ac.uk or on +44 (0) 24 7657 3814, the deputy registrar of the University of Warwick Nicola.Owen@Warwick.ac.uk or +44 (0) 24 7652 2713. Alternatively you can contact Marie-Louise Newell the director of the Africa Centre mnewell@africacentre.ac.za or on +27 (0) 35 5507509.

Do you have any questions you would like to ask me?

You can contact me on:

Alexandra Plowright
0788836056
A.S.Plowright@Warwick.ac.uk

I have read and understand the information sheet ☐

Any questions I have, have been answered ☐

I understand that the participation of my organisation and associated staff members in this research is entirely voluntary, and we are free to withdraw at any time without punishment or being disadvantaged in any way ☐

I agree for my organisation and associated staff members to take part in this study ☐

Name of organisation Date Signature (organisation's representative)

_____ _____ _____

Name of Researcher Date Signature

IMPILO YABESIMAME KWAZULU NATAL

Igama lami ngingu Alex Plowright ngihlala eMonzi, duzane naseMtubatuba. Okwamanje ngiqeqeshela I PHD degree enyuvesi yaseWarwick ese UK.
Ngise Africa Centre lapho ngenza khona ucwaningo. Ngiyanicela ukuthi ningisize ngokungivumela ukuza endaweni yenu yokusebenzela ngibone ukuthi kwenzakalani lapho, mhlawume ngikhulume nabantu abakhona lapho.

Ngaphambi kokuthi nivume ukungisiza kubalulekile ukuthi nginichazele ukuthi yingani ngifuna ukwenza lokhu, negizonicela ukuba ningisize ngakho.

Ngicela nifunde lolulwazi ngokucophelela, uma ninemibuzo noma nidinga ulwazi olunzulu, ngaphambi kokuba usayine ungakhululeka ukuxhumana nami.

LUMAYELANA NANI LOLUCWANINGO ?

Ngithanda ukwazi mayelana nezindlela ezahlukene abantu besimame nabesilisa bamaZulu abazenzayo mayelana nokuthola abantwana, nasebekubonile ngokuthola abantwana.

KUNGANI NGICELIWE UKUBA NGIBAMBE IQHAZA ?

Ngifisa ungisize ngalokhu ngoba indawo yakho yoku sebenza ibalulekile , futhi baningi abantu abasebenza kuyo kanye nabayivakashelayo nsukuzonke.

KUZOKWENZAKALANI UMA NGIVUMA UKUBAMBA IQHAZA ?

Ngifisaukuvakashela indawo yakho yokusebenza ngizobheka ukuthi kwenzakalani lapho, ukuze ngithole ulwazi olunzulumayelana namasiko esiZulu. Ngizofisa ukukhuluma nabesimame abasebenza lapho, ngibabuze ngezinye zezinto engizibonayo, ukuze ngibe nokuqonda okuphelele ngazo. Ngizofisa ukunxenxa abanye omame ukuba bebambe iqhaza ekuphenduleni imibuzo enginayo.

Ngizofisa ukuvumeleka ukuvakasha phakathi kuka April noDecember kulonyaka (2012) usuku lonke, okungenani kanye emasotweni amabili.

Uma uvuma ukuhlanganyela kulolucwaningo, uyacelwa ukuba ushicilele (usayine) ephepheni elilandelayo esikhundleni senhlangano yakho.

NGABE KUYIMFIHLO ?

Imfihlo nokungaziwa kuzoba yingxenye yayo yonke into oyishoyo. Lokhu kusho ukuthi onke amagama ezinhlangano nabantu abazisebenzelayo kuzogcinwa kuymfihlo, futhi imiphumela yocwaningo izogcinwa iyimfihlo ngisho nakuwowonke umuntu osebenzela inhlangano.Futhi inhlangano ngeke ivumeleke ukuthi ichaze ngawe nanoma yini ephathelene nawe engadingi ukuthi yaziwe.

IZOGCINWA KUPHI LEMIQULU YOLWAZI ?

Lonku lolulwazi luzogcinwa iminyaka eyishumi endaweni ephephile, kanye nawo wonke amaphepha aqukethe imishicilelo yabantu izogcinwa endaweni ekhiyiwe. Yimia kuphela ozokwazi lapho kukhona. Yonke into izoba imfihlo.

KWENZAKALANI UMA NGINGASATHANDI UKUBAMBA IQHAZA ?

Kuyilungelo lakho ukungivumela ukuthi ngivakashele endaweni osebenzela kuyona ngizoba nesikhathi nawe, futhi uma usufuna ukuhoxa uvumelekile ngaphandle kwemibandela.

NGIXHUMANA NOBANI UMA NGINOKUBALISA NGALOLUCWANINGO ?

Uma unezinkinga mayelana nalolucwaningo uvumelekile ukuxhumana nomphathi wami uProfesa Gillian.Hundt Gillian.Hundt@Warwick.ac.za noma kulenombolo +44 (0) 24 7657 3814 noma umabhalane wenyuvesi ku Nicole.Owen@Warwick.ac.za inombolo ithi 044 (0) 24 7652 2713 noma umphathi wami wase Africa Centre ku mnewell@africacentre.ac.za . inombolo ithi : 035 550 7509

Ngbe unayo imibuzo ongafisa ukungibuza yona ?

Ungaxhumana nami ku:

Alexandra Plowright
078 883 6056
A.S.Plowright@Warwick.ca.za

Ngifundile ngacacelwa ulwazi olukulomqulu.
Yonke imibuzo ebenginayo, iphendulekile

Ngiyaqonda ukuthi ukuhlanganyela kwenhlangano nabanye babasebenzi kulolucwaningo kungokokuzinikela,futhi sivumelekile ukushiya noma ngayisiphi isikhathi ngaphandle kokulandelelwa.

Ngiyavuma ukuthi inhlangano yami kanye nabanye babasebenzi babambe iqhaza kulesisifundo.

Igama lenhlangano	Usuku	Ukusayina
_____	_____	_____
Igama lomcwaningi	Usuku	Ukusayina
_____	_____	_____

THE UNIVERSITY OF WARWICK

Information Sheet: Centre staff and women attending

Women's health in KwaZulu-Natal

My name is Alex Plowright and I live in Monzi, near Mtubatuba. I am currently studying for a PhD degree with the University of Warwick in the UK and am based at the Africa Centre whilst doing this research. I am inviting you to help me by allowing me to observe you whilst you are at the community centre.

Before you agree to help me, it is important that I explain to you why I want to do this, and what I will be asking you to do.

Please read the rest of this information sheet carefully, and then if you want to ask any questions, or need any more information before you sign the form please feel free to ask me.

What is this PhD project about?

I am interested in finding out about the choices Zulu men and women make and their experiences of having children.

Why am I being asked to take part?

I would like you to help me because I am interested in observing what happens at the centre, what you do on a daily basis and finding out more about isiZulu culture.

What will happen if I agree to take part?

I would like to observe what you do on a daily basis when you are at the centre. I would also like to briefly talk to you so that you can explain things to me that I may not fully understand. Any conversations we have will be in isiZulu. I may also want to ask you to take part in interviews at a later stage. If I do this, I will give you a separate information sheet to fully explain what is involved in agreeing to participate in these interviews.

If you agree to take part in this research, you are required to sign the informed consent form on the next page

Is it confidential?

Confidentiality and Anonymity will apply to anything you say or do. This means that the names of all organisations and people who work for them will be kept secret and anything I observe you doing will not be attributed to you in a way that identifies you. You will never be asked to tell me your health statuses or anything you do not want to say.

Where will data be kept?

Any notes I have made will be kept for ten years safely in a password-protected computer and any papers that have

School of Health and Social Studies
The University of Warwick
Coventry CV4 7AL United Kingdom
Tel: +44 (0)24 76574136
Email: a.s.plowright@warwick.ac.uk

been signed, or that personal details are written on will be kept locked in a secure place. I am the only person who will know where these are. I may use data from my observations in future publications, however any quotes I use will be anonymous.

What if I do not want to participate anymore?

It is entirely your choice whether or not you agree to help me by allowing me to observe you when you are at the centre, and if you wish to withdraw at any time, you can do so without penalization or disadvantage.

Who do I contact if I have any complaints about this research?

If you have any complaints at any stage of this research please do not hesitate to contact me, my university supervisor, Professor Gillian Hundt Gillian.Hundt@Warwick.ac.uk or on +44 (0) 24 7657 3814, the deputy registrar of the University of Warwick Nicola.Owen@Warwick.ac.uk or +44 (0) 24 7652 2713. Alternatively you can contact Marie-Louise Newell the director of the Africa Centre mnewell@africacentre.ac.za or on +27 (0) 35 5507509.

Do you have any questions you would like to ask me?

You can contact me on:

Alexandra Plowright
0788836056
A.S.Plowright@Warwick.ac.uk

I have read and understand the information sheet ☐

Any questions I have, have been answered ☐

I understand that my participation in this research is entirely voluntary, and I am free to withdraw at any time without punishment or being disadvantaged in any way ☐

I agree to take part in this study ☐

Name of participant	Date	Signature
_____	_____	_____
Name of Researcher	Date	Signature
_____	_____	_____

IMPILO YABESIMAME KWAZULU NATAL

Igama lami ngingu Alex Plowright ngihlala eMonzi, duzane naseMtubatuba. Okwamanje ngiqeqeshela I PHD degree enyuvesi yaseWarwick ese UK.
Ngise Africa Centre lapho ngenza khona ucwaningo. Ngiyanicela ukuthi ningisize ngokungivumela ukuza endaweni yenu yokusebenzela ngibone ukuthi kwenzakalani lapho, mhlawume ngikhulume nabantu abakhona lapho.

Ngaphambi kokuthi nivume ukungisiza kubalulekile ukuthi nginichazele ukuthi yingani ngifuna ukwenza lokhu, negizonicela ukuba ningisize ngakho.

Ngicela nifunde lolulwazi ngokucophelela, uma ninemibuzo noma nidinga ulwazi olunzulu, ngaphambi kokuba usayine ungakhululeka ukuxhumana nami.

LUMAYELANA NANI LOLUCWANINGO ?

Ngithanda ukwazi mayelana nezindlela ezahlukene abantu besimame nabesilisa bamaZulu abazenzayo mayelana nokuthola abantwana, nasebekubonile ngokuthola abantwana.

KUNGANI NGICELIWE UKUBA NGIBAMBE IQHAZA ?

Ngifisa ungisize ngalokhu ngoba indawo yakho yoku sebenza ibalulekile , futhi baningi abantu abasebenza kuyo kanye nabayivakashelayo nsukuzonke.

KUZOKWENZAKALANI UMA NGIVUMA UKUBAMBA IQHAZA ?

Ngifisa ukuvakashela indawo yakho yokusebenza ngizobheka ukuthi kwenzakalani lapho, ukuze ngithole ulwazi olunzulumayelana namasiko esiZulu. Ngizofisa ukukhuluma nabesimame abasebenza lapho, ngibabuze ngezinye zezinto engizibonayo, ukuze ngibe nokuqonda okuphelele ngazo. Ngizofisa ukunxenxa abanye omame ukuba bebambe iqhaza ekuphenduleni imibuzo enginayo.

Uma uvuma ukuhlanganyela kulolucwaningo, uyacelwa ukuba ushicilele (usayine) ephepheni elilandelayo.

Igama lobambe iqhaza	Usuku	Ukusayina
Igama lomcwaningi	Usuku	Ukusayina

THE UNIVERSITY OF WARWICK

Information Sheet: Interviews

Women's health in KwaZulu-Natal

My name is Alex Plowright and I live in Monzi, near Mtubatuba. I am currently studying for a PhD degree with the University of Warwick in the UK and am based at the Africa Centre whilst doing this research. I am inviting you to help me by allowing me to interview you.

Before you agree to help me, it is important that I explain to you why I want to do this, and what I will be asking you to do.

Please read the rest of this information sheet carefully, and then if you want to ask any questions, or need any more information before you sign the form please feel free to ask me.

What is this PhD project about?

This project is about what men and women think about having children, and how your opinions and experiences may be different to those your grandchildren or parents have.

Why am I being asked to take part?

I would like you to help me with this because I am interested in finding out more about you, your opinions and your experiences.

What will happen if I agree to take part?

I would like to come and visit you at your house, and interview you individually on two or three occasions. If possible, I would also like to interview you within a group of adult women from your family. This will only happen if they also agree to participate in this study.

All our conversations will be in isiZulu, and there are no right or wrong answers to the questions I will be asking you. The questions are to guide you and help you tell me all about what you think and the experiences that you have had. Our conversations will be tape-recorded. An interpreter may also be there when we are talking just to help me because I am English and sometimes need a bit of help with speaking isiZulu.

If you agree to take part in this research, you are required to sign the informed consent form on the next page.

Is what I say confidential?

Confidentiality and Anonymity will apply to anything you say. This means that the names of all people who agree to help me will be kept secret and everything we talk

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about will not be attributed to you in a way that identifies you. You will not be asked to tell me your health status or anything you do not want to say.

The only time I may have to identify you to other people is if you tell me that something you do is badly hurting someone else. But this will only be after I have talked to you and my university supervisors.

Where will data be kept?

The recordings of interviews will be kept for ten years, safely in a password-protected computer and any papers that you have signed, or that your details are written on will be kept locked in a secure place. I am the only person who will know where these are. I may use data from interviews in future publications, however any quotes used will be anonymous.

What if I do not want to participate anymore?

It is entirely your choice whether or not you agree to help me, and if you wish to withdraw at any time, you can do so without penalization or disadvantage.

Who do I contact if I have any complaints about this research?

If you have any complaints at any stage of this research please do not hesitate to contact me, my university supervisor, Professor Gillian Hundt Gillian.Hundt@Warwick.ac.uk or on +44 (0) 24 7657 3814, the deputy registrar of the University of Warwick, Nicola.Owen@Warwick.ac.uk or +44 (0) 24 7652 2713. Alternatively you can contact Marie-Louise Newell the director of the Africa Centre mnewell@africacentre.ac.za or on +27 (0) 35 5507509.

Do you have any questions you would like to ask me?

You can contact me on:

Alexandra Plowright
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Thank you for your help.

I have read and understand the information sheet ☐

Any questions I have, have been answered ☐

I understand that I do not have to agree to be interviewed and that I can stop an interview at anytime ☐

I understand that my participation in this research is entirely voluntary, and I am free to withdraw at any time without punishment or being disadvantaged in any way ☐

I agree to take part in this study ☐

I agree to take part in the interviews 

I agree to be tape-recorded 

Name of Participant	Date	Signature
_____	_____	_____

Name of Researcher	Date	Signature
_____	_____	_____

IMPILO YABESIMAME KWAZULU NATAL

Igama lami ngingu Alex Plowright ngihlala eMonzi, duzane naseMtubatuba. Okwamanje ngiqeqeshela I PHD degree enyuvesi yaseWarwick ese UK.
Ngise Africa Centre lapho ngenza khona ucwaningo. Ngiyanicela ukuthi ningisize ngokungivumela ukuza endaweni yenu yokusebenzela ngibone ukuthi kwenzakalani lapho, mhlawume ngikhulume nabantu abakhona lapho.

Ngaphambi kokuthi nivume ukungisiza kubalulekile ukuthi nginichazele ukuthi yingani ngifuna ukwenza lokhu, negizonicela ukuba ningisize ngakho.

Ngicela nifunde lolulwazi ngokucophelela, uma ninemibuzo noma nidinga ulwazi olunzulu, ngaphambi kokuba usayine ungakhululeka ukuxhumana nami.

LUMAYELANA NANI LOLUCWANINGO ?

Ngithanda ukwazi mayelana nezindlela ezahlukene abantu besimame nabesilisa bamaZulu abazenzayo mayelana nokuthola abantwana, nasebekubonile ngokuthola abantwana.

KUNGANI NGICELIWE UKUBA NGIBAMBE IQHAZA ?

Ngifisa ungisize ngalokhu ngoba indawo yakho yoku sebenza ibalulekile , futhi baningi abantu abasebenza kuyo kanye nabayivakashelayo nsukuzonke.

KUZOKWENZAKALANI UMA NGIVUMA UKUBAMBA IQHAZA ?

Ngifisa ukuvakashela emzini wakho nginibuze imibuzo, mhlampe izigaba ezintathu ezahlukene. Uma kungenzeka ngingacela ukubuza imibuzo phakathi kwabanye abesimame emndenini. Lokhu kuzokwenzeka uma nabo bevuma ukuba yingxenye yalesisifundo.

Zonke izingxoxo zethu zizoba ngesiZulu, futhi kuzobe kungekho okuyiqiniso noma okungasilo iqiniso kulemibuzo engizobe ngikubuza yonaimibuzo izobe ikuqondisa futhi ikulekelela ukuthi ungitshele ngokucabangayo,nosewake wakubona,nosewake wakuzwa. Izingxoxo zethu zizoqoshwa. Kuzoba khona notolika ozosisiza ngoba ngiliNgisi ngibuye ngibe nenkinga ekukhulumeni isiZulu.

Uma uvuma ukuhlanganyela kulolucwaningo, uyacelwa ukuba ushicilele (usayine) ephepheni elilandelayo.

NGABE ENGIKUSHOYO KUYIMFIHLO ?

Imfihlo nokungaziwa kuzoba yingxenye yayo yonke into oyishoyo. Lokhu kusho ukuthi onke amagama abantu azogcinwa eymfihlo, futhi imiphumela yocwaningo izogcinwa

iyimfihlo. Angeke ubuzwe ukuthi uchaze ngempilo yakho nangobuwena nanoma yini ongathandi ukuthiyaziwe ngawe.
Isikhathi engingakuveza ngaso , uma wena ungitshela ukuthi okwenzayo kulimaza abanye abantu. Kodwa lokho kungaba emveni kokuba ngikhulume nawe kanye nomphathi wami weseNyuvesi.

IZOGCINWA KUPHI LEMIQULU YOLWAZI ?

Lonku lolulwazi luzogcinwa iminyaka eyishumi endaweni ephephile, kanye nawo wonke amaphepha aqukethe imishicilelo yabantu izogcinwa endaweni ekhiyiwe. Yimina kuphela ozokwazi lapho kukhona. Yonke into izoba imfihlo.

KWENZAKALANI UMA NGINGASATHANDI UKUBAMBA IQHAZA ?

Kuyilungelo lakho ukuthi uyavuma noma awuvumi ukungisiza, futhi uma usufuna ukuhoxa uvumelekile ngaphandle kwemibandela.

NGIXHUMANA NOBANI UMA NGINOKUBALISA NGALOLUCWANINGO ?

Uma unezinkinga mayelana nalolucwaningo uvumelekile ukuxhumana nomphathi wami uProfesa Gillian.Hundt Gillian.Hundt@Warwick.ac.za noma kulenombolo +44 (0) 24 7657 3814 noma umabhalane wenyuvesi ku Nicole.Owen@Warwick.ac.za inombolo ithi 044 (0) 24 7652 2713 noma umphathi wami wase Africa Centre ku mnewell@africacentre.ac.za . inombolo ithi : 035 550 7509

Ngabe unayo imibuzo ongafisa ukungibuza yona ?

Ungaxhumana nami ku:

Alexandra Plowright
078 883 6056
A.S.Plowright@Warwick.ca.za

Ngiyabonga ngosizo lwakho.

Ngifundile ngacacelwa ulwazi olukulomqulu.
Yonke imibuzo ebenginayo, iphendulekile

Ngiyaqonda ukuthi angphoqelekile ukuthi ngibuzwe imibuzo, futhi ngingakumisa nanoma yinini uma ngingasafuni.

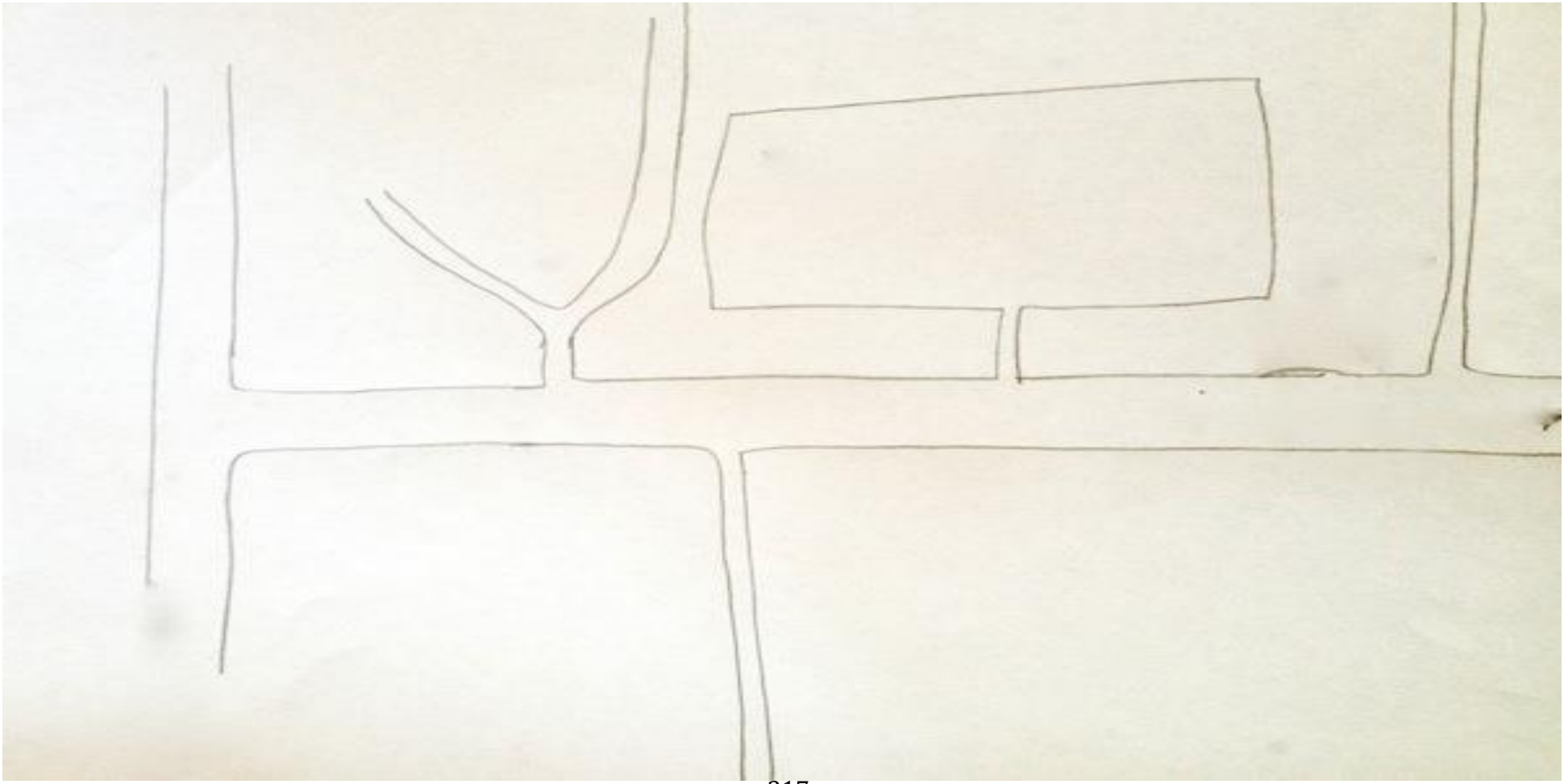
Ngiyaqonda ukuthi ukuhlanganyela kwami kulolucwaningo kungokokuzinikela,futhi ngivumelekile ukushiya noma ngayisiphi isikhathi ngaphandle kokulandelelwa.

Ngiyavuma ukuba yingxenye yalokukufunda.

Appendix 4: Details about Service Provider and Key Informant Participants

Interview #	Participant's role	Date	Work location of participant	Type of interview	Length of interview	Location of interview
1	Sister 1	25.1.13	Village C clinic	Individual	45m	Clinic
2	Sister 2	25.1.13	Village C clinic	Individual	40m	Clinic
3	Brother of Zion	4.2.13	Zionist church Village C	Individual	2h30m	House in Village C
4	Sangoma	17.3.2012	Village C	Individual	Whole day (5am – around 4pm – she agreed for me to spend the whole day with her)	"Consulting rooms" in Village C
5	ZCC healer (male)	18.3.2013	Kwa M'Sane, town near to Khaya'manzi	Individual	1 hour	ZCC designated church area outside Zwenalisha
6	Farming couple who financially support the Community Project	17.8.2013	Community Project in Khaya'manzi	Group (x2 participants)	1 hour 10 minutes	Community Project office
7	Richard, farm foreman	18.8.2013	Khaya'manzi farming area, close to village D	Individual	30 minutes	Farm office

Appendix 5: Example of Hand-Drawn Map Used in Modified Participatory Mapping Exercise



Appendix 6: SADHS Survey Sample Breakdown by Year and Province

Table A6.1: Breakdown of survey sample by year

Year of survey	Frequency	Percentage
1998	11735	62.5%
2003	7041	37.5%
Total	18776	100%

Table A6.2: Breakdown of survey sample from 1998 and 2003 by province

Region	Year of survey	
	1998	**2003**
Western Cape	919 (7.8%)	715 (10.2%)
Eastern Cape	2756 (23.4%)	505 (7.2%)
Northern Cape	1041 (8.9%)	777 (11.0%)
Free State	936 (8%)	796 (11.3%)
KwaZulu-Natal	1826 (15.6%)	1219 (17.3%)
North West	931 (7.9%)	749 (10.6%)
Gauteng	1057 (9%)	722 (10.3%)
Mumalanga	1131 (9.6%)	776 (11%)
Northern Province	1138 (9.8%)	782 (11.1%)
Total	11735 (100%)	7041 (100%)

Appendix 7: Map Drawn By "Wendy" a 21-year old Participant in Participatory Mapping Exercise

Map Drawn By "Nelly" a 45-year old Participant in Participatory Mapping Exercise